Sage Massage, Acupuncture & Herbal Medicine

New Patient Intake Form

Name_____ Date_____

Address_____ Phone_____

City State Zip_____ May we leave a message? Y N

Date of Birth_____ Email_____

Age_____

Emergency Contact_____ Phone_____

How did you hear about us? _____ Friend □ Website □ Ad □ Doctor □ Other □

A note to patients: *Welcome to Sage Massage and Acupuncture! Successful health care and preventative medicine are only possible when the practitioner has a complete picture of the patient physically, mentally and emotionally. Please take the time to complete this health history questionnaire. I look forward to working with you.*

List your primary reasons you are seeking treatment in order of importance.

1. _____
When how did this condition occur? _____
Treatments you have received for this condition? _____
Current medication? _____

2. _____
When how did this condition occur? _____
Treatments you have received for this condition? _____
Current medication? _____

3. _____
When how did this condition occur? _____
Treatments you have received for this condition? _____
Current medication? _____

Please list any foods, drugs or medications you are hypersensitive or allergic to (please include reaction).

_____
_____

Your Current Doctor's: Name_____ Phone _____
Insurance: Name of Insurance_____ Policy ID#_____
Phone_____ Group #_____
Address_____

For the following symptoms, please mark:
YES (a condition you have now) **PAST** (a condition no longer present)

Yes	Past		Yes	Past	
		Head & Neck			Mouth & Throat
☐	☐	TMJ	☐	☐	Frequent sore throat
☐	☐	Migraines	☐	☐	Teeth grinding
☐	☐	Headaches	☐	☐	Bleeding gums
☐	☐	Dizziness	☐	☐	Mouth ulcers
☐	☐	Fainting	☐	☐	Loss of voice
☐	☐	Head Injury	☐	☐	Hoarseness
			☐	☐	Dry mouth
		Eyes	☐	☐	Bad Breath
☐	☐	Blurry			
☐	☐	Floater			Skin
☐	☐	Cataracts	☐	☐	Rashes
☐	☐	Tearing	☐	☐	Eczema
☐	☐	Dryness	☐	☐	Itching
☐	☐	Glaucoma	☐	☐	Acne/boils
☐	☐	Eye Pain	☐	☐	Lumps
☐	☐	Sensitivity to light	☐	☐	Hair loss
			☐	☐	Color changes
		Ears	☐	☐	Slow healing wounds
☐	☐	Discharge from ears	☐	☐	Dry skin
☐	☐	Hearing problems	☐	☐	Hives/Rashes
☐	☐	Pain in ears	☐	☐	Psoriasis
☐	☐	Ringing in ears	☐	☐	Night sweating
☐	☐	Many ear infections	☐	☐	Excess sweating
			☐	☐	Bruise easily
		Nose & Sinus			
☐	☐	Nose Bleeds			Respiratory
☐	☐	Hay fever	☐	☐	Cough
☐	☐	Loss of smell	☐	☐	Asthma
☐	☐	Nasal congestion	☐	☐	Pneumonia
☐	☐	Sinus infection	☐	☐	Emphysema
☐	☐	Frequent colds	☐	☐	Tuberculosis
			☐	☐	Asthma/Wheezing
		Neck	☐	☐	Bronchitis
☐	☐	Lumps	☐	☐	Pleurisy
☐	☐	Enlarged Lymph Glands	☐	☐	Chronic cough
☐	☐	Goiter	☐	☐	Coughing up blood
☐	☐	Constriction	☐	☐	Coughing up phlegm
☐	☐	Phlegm	☐	☐	Difficulty breathing
☐	☐	Hypothyroid	☐	☐	Shortness of breath
☐	☐	Hyperthyroid	☐	☐	Pain while breathing

Yes	Past	Cardiovascular
☐	☐	Palpitations
☐	☐	Chest pain or tightness
☐	☐	Rapid heart beat
☐	☐	Irregular heat beat
☐	☐	Heart disease
☐	☐	Poor circulation
☐	☐	Cold hands/feet
☐	☐	Swelling ankles
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Anemia
☐	☐	Blood clots
☐	☐	Phlebitis
☐	☐	Heart murmurs
☐	☐	Stroke

		Urinary
☐	☐	Pain on urination
☐	☐	Frequent night urination
☐	☐	Frequent day urination
☐	☐	Blood in urine
☐	☐	Inability to hold urine
☐	☐	Kidney disease/stones
☐	☐	UTI/bladder infection
☐	☐	Weak stream/dribbling

		Neurological
☐	☐	Seizures/epilepsy
☐	☐	Muscle weakness
☐	☐	Loss of memory
☐	☐	Vertigo or dizziness
☐	☐	Paralysis
☐	☐	Numbness or tingling
☐	☐	Loss of balance
☐	☐	Tremors

Yes	Past	Gastrointestinal
☐	☐	Indigestion
☐	☐	Nausea
☐	☐	Vomit
☐	☐	Bloating
☐	☐	Gas
☐	☐	Heartburn
☐	☐	Distention of abdomen
☐	☐	Stomach pain
☐	☐	Irritable Bowel
☐	☐	Colitis
☐	☐	Crohn's Disease
☐	☐	Celiac Disease
☐	☐	Ulcer
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Dry, hard stools
☐	☐	Soft, sticky stools
☐	☐	Blood in stool/black stools
☐	☐	Hemorrhoids
☐	☐	Poor appetite
☐	☐	Excessive hunger
☐	☐	Excessive thirst
☐	☐	Gall Bladder problem/stones
☐	☐	Recent weight change
☐	☐	Food cravings
☐	☐	Hypoglycemia
☐	☐	Trouble swallowing
☐	☐	Pain or cramps
☐	☐	No thirst
☐	☐	Excess thirst

		Muscle & Joint
☐	☐	Muscle spasms or cramps
☐	☐	Arthritis
☐	☐	Weakness
☐	☐	Back pain
☐	☐	Soreness
☐	☐	Pain and stiffness
☐	☐	Broken bones
☐	☐	Stiffness

Yes	Past	
		Emotional
☐	☐	Mood swings
☐	☐	Excessive worry
☐	☐	Anxiety/nervousness
☐	☐	Depression
☐	☐	Tension
☐	☐	Panic attacks
☐	☐	Considered/attempted suicide
☐	☐	Insomnia
☐	☐	Poor memory
☐	☐	Difficulty concentrating
		Infection
☐	☐	HIV/AIDS
☐	☐	TB
☐	☐	Hepatitis
☐	☐	STD
☐	☐	Herpes
		Male reproduction
☐	☐	Hernias
☐	☐	Testicular pain
☐	☐	Discharge or sores
☐	☐	Premature ejaculation
☐	☐	Impotence
☐	☐	Painful erection
☐	☐	Prostate issues
☐	☐	Low sex drive
☐	☐	Weak erection
		Female reproduction/breasts
☐	☐	Cycles irregular
☐	☐	Bleeding between cycles
☐	☐	Pain during intercourse
☐	☐	Infertility
☐	☐	PID
☐	☐	Ovarian cysts
☐	☐	Endometriosis
☐	☐	Hot flashes
☐	☐	Mastitis
☐	☐	Breast cysts
☐	☐	Breast tenderness
☐	☐	Yeast Infections/Vaginitis
☐	☐	Fluid retention during period
☐	☐	PMS irritability/depression
☐	☐	Post-menopausal bleeding

Do you have a period? ☐ Yes ☐ No
If '**no**', when was your last period? _____

Color of menstrual flow:
☐ Dark red ☐ Bright red ☐ Brown
☐ Purple ☐ Pale/diluted

Volume of menstrual flow:
☐ Heavy ☐ Moderate ☐ light ☐ none

Number of days in your monthly cycle? _____

Do you suffer from cramping?
☐ Before period ☐ During period ☐ After period
☐ Severe ☐ Moderate ☐ Mild

Do you suffer from menstrual clotting?
☐ Yes ☐ No
☐ Bright in color ☐ Dark in color
☐ Dime size ☐ Quarter size

Birth control? ☐ Yes ☐ No
What type? _____

_____

Medications: **Please list *all*** prescription, supplement and over-the-counter **medications you are currently taking:**

Name	Dosage	Reason