

# The Yellow Door

Classical Acupuncture  
Jodie Hieber, L.A.C

## NEW PATIENT INTAKE FORM

Name: \_\_\_\_\_ DOB/AGE: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Please indicate how you would like to be contacted (circle one): Home phone / Mobile / Text / Email

Emergency contact name and number: \_\_\_\_\_

Your occupation: \_\_\_\_\_

Marital status: \_\_\_\_\_

Living situation: \_\_\_\_\_

Whom may I thank for referring you? \_\_\_\_\_

Please list the names & phone numbers of any Drs. Or Practitioners you would like me to consult with:

Please list ALL prescription and non-prescription drugs (i.e. over the counter, vitamins, supplements, herbs, etc.) currently being taken. Include any taken occasionally, such as aspirin for headaches, as well as those taken daily. (Use back of page if needed.)

Name	Dose and how often	Reason for taking
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

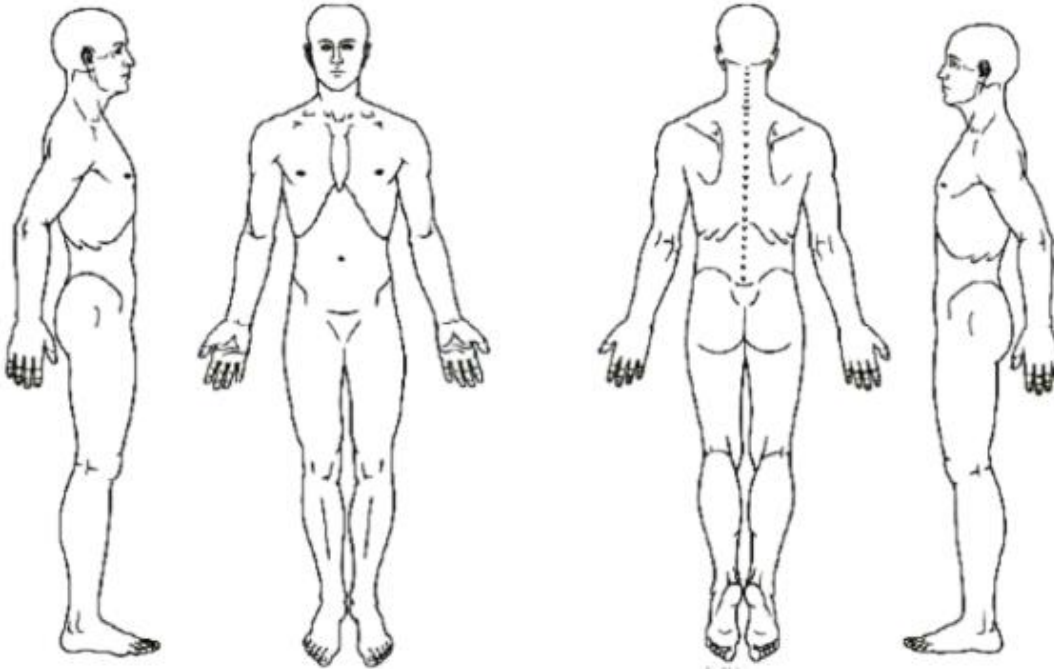
11. \_\_\_\_\_

What is the primary concern you would like to address in treatment? \_\_\_\_\_

Other issues or concerns? \_\_\_\_\_

**Musculoskeletal:**

Using an X, please indicate any areas of current pain or weakness of the diagram below:



Please describe each: \_\_\_\_\_

Please list any past accidents, injuries or surgeries, including dates: \_\_\_\_\_

Do you experience numbness and/or tingling in any part of your body? Yes / No

If yes, please explain: \_\_\_\_\_

**Exercise:**

Type and frequency of exercise / movement: \_\_\_\_\_

**Sleep:**

What time do you go to sleep? \_\_\_\_\_

What time do you wake? \_\_\_\_\_

Do you feel rested when you wake? Yes / No

Difficulty: Falling asleep / Staying asleep / Toss & turn / Waking early, unable to get back to sleep

Dreams: Vivid dreams / Nightmares / I don't dream

Other sleep issues: \_\_\_\_\_

**Temperature:**

Do you tend to feel hot or cold and/or experience hot flashes or cold chills? Yes / No

If yes, please explain: \_\_\_\_\_

Do your feet and/or hands tend towards cold? Yes / No

If yes, please explain: \_\_\_\_\_

**Stress & Anxiety:**

What is your level of stress and/or anxiety on a scale of 1 -10 (10 being the most stressed / anxious): \_\_\_\_\_

What triggers your stress / anxiety? \_\_\_\_\_

Do you have panic attacks? Yes / No

If yes, please describe: \_\_\_\_\_

What helps you conquer stress / anxiety? \_\_\_\_\_

\_\_\_\_\_

**Energy level:**

(Use a scale of 1 -10, 10 being having enough energy to get through your day easily with some left over)

Overall: \_\_\_\_\_

Upon waking: \_\_\_\_\_

Time of day of peaks and low ebbs: \_\_\_\_\_

**Headaches:**

Do you get headaches? Yes / No

If yes, how often? Occasionally / Weekly / Daily

Where does it occur in or on your head, and what does it feel like? \_\_\_\_\_

Do you experience dizzy spells? Yes / No

If yes, how often? Occasionally / Weekly / Daily

**Memory:**

Do you have any issues with your memory? Yes / No

If yes, please explain: \_\_\_\_\_

“Foggy” brain or “fuzzy” thinking? Yes / No

If yes, please explain: \_\_\_\_\_

**Eyes:** Issues with Vision / Floaters / Dryness / Redness / Itchy / Other: \_\_\_\_\_

**Nose:** Congestion / Runny / Decreased sense of smell / Other: \_\_\_\_\_

**Ears:** Ringing / Loss of Hearing / Sound Sensitivity / Rushing Noise / Other: \_\_\_\_\_

**Allergies:**

Do you have allergies to foods, products, and/or environment: Yes / No

If yes, please explain: \_\_\_\_\_

Is it seasonal: Yes / No

**Teeth/Jaw:** TMJ / Teeth Grinding / Jaw Pain / Other: \_\_\_\_\_

**Chest & Breathing:**

Tightness / Pain / Palpitations / Asthma / Shortness of Breath / Other: \_\_\_\_\_

How often? Occasionally / Weekly / Daily / Other: \_\_\_\_\_

Cough: Morning / Daytime / Nighttime/ All the time

Is it: Dry / Phlegm Producing / Difficult to expectorate Phlegm

What color, if any, is the phlegm? Clear / White / Yellow / Brown / Green

Do you use tobacco (currently or in the past)? Yes / No

If yes, for how long and how often per day / week? \_\_\_\_\_

**Appetite:**

Do you get hungry during the day? Yes / No

Do you feel like you eat too much or too little? Too much / Too little / No

Do you feel energized after eating or feel like you need a nap? Energized / Nap

Do you crave anything: \_\_\_\_\_

**Diet:** What does your food intake on a typical day look like? Please include times of meals.

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

**Digestion:**

Do you experience: Bloating / Pain after eating / BM after eating / Frequent gas / Heartburn / Reflux

Other: \_\_\_\_\_

**Abdominal Pain:**

Location of pain (if any): Middle Abdomen / Lower Abdomen / Both

Related to food intake? Yes / No / Sometimes

What does the pain feel like? Dull / Sharp / Like a Spasm

What makes it feel better? Pressure / Heat / Cold / Other: \_\_\_\_\_

**Fluid Intake:**

Do you get thirsty? Yes / No

How much water do you drink in a day? \_\_\_\_\_

How much coffee do you drink in a day? \_\_\_\_\_

What kinds of soda do you drink and how often? \_\_\_\_\_

What other kinds of beverages (including alcohol) do you drink and how often? \_\_\_\_\_

Do you consume "diet" drinks with sugar substitutes? Yes / No

If yes, what kind? \_\_\_\_\_

What temperature do you prefer your drinks to be? Cold / Room Temp / Warm / Hot

**Bowels:**

How many times a day/week do you have a BM? \_\_\_\_\_

Any difficulty in going? Yes / No If yes, please describe: \_\_\_\_\_

Any pain? Yes / No If yes: Before / During / After

Any blood or mucus in your stool? Yes / No

Stool description(s): Well formed / Soft / Tend toward diarrhea / Tend toward constipation

Is the stool ever extra smelly? Yes / No

Any current or past hemorrhoids? Yes / No

**Urination:**

Do you feel your output is about equal to your intake? Yes / No

Any dribbling? Yes / No

Any incontinence? Yes / No

Any blood in your urine? Yes / No

Does it ever burn? Yes / No

Color of urine? Clear / Light yellow / Yellow / Dark Yellow

**Menstruation:**

Age of onset: \_\_\_\_\_ Age of menopause: \_\_\_\_\_

Number of days in cycle: \_\_\_\_\_

Duration of period: \_\_\_\_\_

Color of menses: \_\_\_\_\_

Any clots? Yes / No If yes, what size? Pea / Dime / Quarter Other: \_\_\_\_\_

Pain (before or during period): Yes / No / Sometimes Pain level 1 – 10 (10 being worst): \_\_\_\_\_

What makes it feel better? Pressure / Heat / Cold / Other: \_\_\_\_\_

Breast tenderness: Yes / No / Sometimes

Mood changes: Yes / No / Sometimes

Hot flashes: Yes / No / Sometimes

Any other PMS symptoms: \_\_\_\_\_

**Pregnancy History:**

Are you currently pregnant? Yes / No If yes, how many weeks? \_\_\_\_\_ Due Date: \_\_\_\_\_

Number of previous pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_

Health during pregnancy: \_\_\_\_\_

Complications during labor and delivery: \_\_\_\_\_

Health postpartum: \_\_\_\_\_

Are you currently breastfeeding? Yes / No

**Prostate:**

Have you had a prostate exam? Yes / No

If yes, when? \_\_\_\_\_

Any concerns? Yes / No

If yes, please explain: \_\_\_\_\_

**Please Briefly describe your vision of yourself in perfect health:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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*I hereby certify that the information above is complete and to the best of my knowledge.*

Patient Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature (Signature of parent or guardian if under 18): \_\_\_\_\_