Acupuncture Sports Medicine ™

ANCHORAGE
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pain • injury • rehabilitation • prevention • performance

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New Patient Intake Form

Name		
Home Phone	Business Phone	Cell Phone
Email Address		
Street Address		
City	State	Zip
Birthdate	Occupation	
Contact Name in Emergencies	Emergency Contact Phone	
Primary Physician		
Referred by		

Insurance Information (please print & fill out our Insurance Form)

Do you have insurance? ☐ Yes ☐ No

Insurance Company Name

Primary Reason(s) for your Visit

Date of Onset	Condition / Injury / Painful Area	Left/Right (or both)

Check all that apply to your symptoms:

☐ Work Related Injury ☐ Reoccurence of previous injury ☐ Motor Vehicle Accident ☐ Injury Related to Lifting ☐ Athletic or Recreational Injury

☐ Cause Unknown ☐ Other (describe)

Please list all accidents or injuries starting with the most recent.

Date	Accident, injury or trauma

Please list all hospitalizations, surgeries or serious illness starting with the most recent.

Date	Surgery or serious illness

What other therapies have you tried for your pain?

Date	Treatment

What evaluations, scans or blood tests have been done? (X-Rays, MRI's, CT Scans, etc.)

Date	Evaluation, Scans or Blood Tests

Pain Description

How would you describe your pain?
What increases your pain?
What relieves your pain?
Does your pain occur with certain movements or positions?
Do you have limited range of motion or loss of function? Please explain.
Does your pain have associated symptoms such as numbness, tingling, swelling or weakness?
Is the pain worse at night or in the morning?
Is your pain worse or better at rest?
Does your pain improve with stretching or movement?
Is your pain worse or better while sitting, standing, or walking?
Does your pain change with the weather?
Does your pain have chronic and acute cycles?
Do you do repetitive strain activities at work or leisure?
Does the pain limit your activities? Please explain.
Do you have metal implants or prosthesis?
Do you have osteoarthritis, osteoporosis, fibromyalgia or other systemic musculoskeletal disorder?

What medications are you taking?

Date	Medications

What supplements/herbs are you taking?

Date	Supplements/ Herbs

Do you have any of the following conditions? (Please put an X in the appropriate box.)

Head, Eyes, Ears, Nose & Throat
- ☐ Headache
- ☐ Eye pain / strain
- ☐ Glaucoma
- ☐ Blurry vision
- ☐ Sinus problems
- ☐ Seasonal Allergies
- ☐ Nose Bleeds
- ☐ Ear Aches
- ☐ Ear Ringing
- ☐ Sore Throat
- ☐ TMJ / Teeth Grinding
- ☐ Dental Problems

Cardiovascular
- ☐ Heart Disease
- ☐ Palpitations
- ☐ Dizziness / Fainting
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Rapid Pulse
- ☐ Varicose Veins
- ☐ Swelling of Ankles
- ☐ Cold Hands / Feet
- ☐ Blood thinners
- ☐ Pacemaker
- ☐ Stroke

Respiratory
- ☐ Chronic cough
- ☐ Frequent respiratory infections
- ☐ Asthma
- ☐ Rescue Inhaler
- ☐ Smoker
- ☐ Pneumonia / bronchitis
- ☐ Airborne Allergies

Gastrointestinal
- ☐ Epigastric pain
- ☐ Nausea / Vomiting
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Changes in Appetite
- ☐ Gas/Bloating
- ☐ Liver/Gall Bladder problems
- ☐ Hepatitis B or C
- ☐ Abdominal pain
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood or mucus in stool
- ☐ Abdominal surgery
- ☐ Food Allergies
- ☐ Special diet

Urinary Tract
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Frequent Infection
- ☐ Nighttime Urination
- ☐ Impaired Urination
- ☐ Kidney Stones

Hormonal / Menstrual
- ☐ Breast lumps / Tenderness
- ☐ Irregular Mammogram
- ☐ Breast Cancer / Surgery
- ☐ Premenstrual Syndrome
- ☐ Irregular Cycles
- ☐ Heavy / Painful Periods
- ☐ Vaginal Infections
- ☐ Irregular PAP
- ☐ Menopausal Symptoms
- ☐ Pregnant
- ☐ History of C-section

Males
- ☐ Prostate Problems
- ☐ Erectile Dysfunction
- ☐ Testicular Pain

Endocrine
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other Endocrine Disorders

Neurological System
- ☐ Poor Balance
- ☐ Dizziness/Vertigo
- ☐ Numbness
- ☐ Tingling
- ☐ Epilepsy
- ☐ Seizures

Other
- ☐ Low energy / Fatigue
- ☐ Mood swings
- ☐ Anxiety
- ☐ Insomnia
- ☐ Stress/Tension
- ☐ Rashes/Skin Disorders
- ☐ Chronic Infections
- ☐ Sensitivity to Hot/Cold
- ☐ Chills/Fever
- ☐ Chronic Illness
- ☐ Cancer

Signature	Date