



**Tamsen Staniford L.Ac.**  
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**New Patient Initial Intake Form**

This is a CONFIDENTIAL questionnaire to help us work together to determine the best treatment plan for you. Please fill it out as completely as possible, even if you do not feel certain questions pertain to your present condition.

Date \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Birth date \_\_\_\_\_ Gender F M T Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Phone number \_\_\_\_\_ Cell phone number \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_

If under 18, person responsible for your account \_\_\_\_\_

How did you hear about my practice? \_\_\_\_\_

Have you had acupuncture before?  Yes  No

Where? \_\_\_\_\_

Primary Care Physician information: Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ How long? \_\_\_\_\_

**Current Health Status and Health History**

What are the health problems for which you are seeking treatment?

\_\_\_\_\_ How long? \_\_\_\_\_

Has an MD diagnosed the condition? \_\_\_\_\_ When? \_\_\_\_\_

What other forms of treatment have you sought, did they help?

\_\_\_\_\_

What helps your condition?

\_\_\_\_\_

What aggravates your condition?

Please  which of the following you are interested in to achieve your health goal:

- Acupuncture  Acupressure  Herbs  Supplements  Nutrition
- Exercise  Lifestyle changes  Meditation  Relaxation techniques

Please list your surgeries or major health incidents (accidents, major illness, etc.) past or present:

\_\_\_\_\_ Year \_\_\_\_\_      \_\_\_\_\_ Year \_\_\_\_\_  
 \_\_\_\_\_ Year \_\_\_\_\_      \_\_\_\_\_ Year \_\_\_\_\_

**Please indicate the following:**

	Yourself	Family member (whom)	Year	Status
Diabetes				
High Blood Pressure				
Heart Disease				
High Cholesterol				
Cancer				
Autoimmune Disorders				
Genetic Disorders				
Anxiety/Depression				
Mental Illness				
Arthritis				

**Please list the following:**

Allergies \_\_\_\_\_

Medications (prescription and over the counter)	Reason	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please ✓ if any of the following pertain to you:**

\_\_\_ Pacemaker    \_\_\_ Blood thinners    \_\_\_ Low blood pressure    \_\_\_ Seizures    \_\_\_ Bleeding disorders

**Please indicate the use and frequency of the following:**

Coffee \_\_\_\_\_ Soda pop \_\_\_\_\_ Water \_\_\_\_\_  
 Alcohol \_\_\_\_\_ Recreational drugs \_\_\_\_\_ Tobacco \_\_\_\_\_

**Please ✓ any symptoms you currently experience:**

___ Difficulty Sleeping	___ Loss of Appetite	___ Headaches	___ Loss of Motor Function
___ Difficulty Urinating	___ Sudden Increase in Appetite	___ Dizziness	___ Loss of Sensation
___ Loose Stool	___ Sudden Weight Loss	___ Loss of Hearing	___ Numbness or Tingling
___ Constipation	___ Night Sweats	___ Loss of Vision	___ Severe Chest Pain
___ Blood in Stool or Urine			

Please list any other symptoms that concern you:

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### For Women

Date of last PAP \_\_\_\_\_ Results \_\_\_\_\_ Date of last breast exam \_\_\_\_\_ Results \_\_\_\_\_

Age of 1<sup>st</sup> period \_\_\_\_ Date of final period \_\_\_\_\_ Number of live births \_\_\_\_\_

Method of birth control \_\_\_\_\_ Are you currently pregnant? \_\_\_\_\_

Number of days between periods \_\_\_\_\_ Number of days of flow \_\_\_\_\_

Color of flow: Amount of flow: # of pads per day Pain and cramping:

- |   |  |                           |                      |
|---|--|---------------------------|----------------------|
| <input type="checkbox"/> pale/light red | <input type="checkbox"/> spotting        | 1 <sup>st</sup> day _____ | No                   |
| <input type="checkbox"/> red            | <input type="checkbox"/> light           | 2 <sup>nd</sup> day _____ | Yes:                 |
| <input type="checkbox"/> bright red     | <input type="checkbox"/> even throughout | 3 <sup>rd</sup> day _____ | before flow mild     |
| <input type="checkbox"/> dark red       | <input type="checkbox"/> heavy           | 4 <sup>th</sup> day _____ | during flow moderate |
| <input type="checkbox"/> dark red/brown |  | 5 <sup>th</sup> day _____ | after flow severe    |
|   |  | + days _____              |                      |

Please ✓ any other symptoms you experience:

- |   |   |                                      |  |                                       |
|---|---|--------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> unusual discharge  | <input type="checkbox"/> PMS                | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Nausea                          | <input type="checkbox"/> constipation |
| <input type="checkbox"/> loose stool        | <input type="checkbox"/> vomiting           | <input type="checkbox"/> mood swings | <input type="checkbox"/> breast tenderness               |                                       |
| <input type="checkbox"/> increased appetite | <input type="checkbox"/> decreased appetite |                                      | <input type="checkbox"/> pain during sex or masturbation |                                       |

### For Men

Date of last prostate exam \_\_\_\_\_ Results \_\_\_\_\_ PSA test results \_\_\_\_\_

Date of last colonoscopy \_\_\_\_\_ Results \_\_\_\_\_

Any testicular problems (torsion, undescended testical, infection, hydrocele, etc...):

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Please ✓ any symptoms you experience:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> abnormal penile discharge         | <input type="checkbox"/> waking at night to urinate                     | <input type="checkbox"/> painful urination |
| <input type="checkbox"/> painful ejaculation               | <input type="checkbox"/> pain during sex or masturbation                | <input type="checkbox"/> swollen testes    |
| <input type="checkbox"/> itching or flaking of penile skin | <input type="checkbox"/> unusual bumps or sore on testes, penis or anus |  |