LifePoint Medical Consultants, LLC

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New Patient Intake Form

Name_____Date_____SS#_____

DOB_____Age_____Email_____

Address_____City_____St_____Zip_____

Phone_____Occupation_____

Check here if we can email you updates and newsletters _____

Marital status_____Ht._____Wt._____

Allergies_____

Emergency Contact Name_____Phone_____

Physician Name_____Phone_____

Have you received Acupuncture before?_____

Are you comfortable with Acupuncture?_____

What is your chief
complaint?_____
_____
_____
_____
_____
_____

Does it bother your Work_____Daily Function_____Sleep_____Other

Was there an event to cause this?_____

What makes it better or worse?_____

Are you in pain right now?_____

Describe your pain
exactly_____
_____

_____
_____

Family Medical History_____
_____
_____

FMH(cont)

Heart Disease	Arteriosclerosis	Seizures	Cancer
Diabetes	Asthma	Stroke	HTN
Genetic	MS	Smoker	Other

Alcoholism

List your current prescribed medications, OTC's and supplements_____
_____
_____
_____
_____
_____
_____

Lifestyle

Smoke and # daily_____ Alcohol and # daily_____

Tobacco_____Stress_____ Recreational drugs_____

Occupational Hazards_____

Exercise/Type/How often_____
_____

Personal Medical History Summary_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____
_____
_____
_____

Surgeries and year performed

_____
_____
_____
_____
_____
_____

Musculoskeletal Symptoms

Pain, location,
character_____
_____
_____
_____

Therapies that you have received for this
condition_____
_____
_____
_____
_____

Imaging and laboratory findings pertinent to this
condition_____
_____
_____
_____
_____
_____

<u>For female patients only</u>:

Are you pregnant?_____

Are you on birth control?_____

How many children do you have?_____

Are you on your menstrual cycle?_____

Describe your menstrual
cyle_____
_____
_____
_____
_____

List any other information that is pertinent to your
visit_____
_____
_____
_____
_____
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