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**New Patient Information Form**

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully.  
All answers are confidential. Please print clearly in ink.

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Leave Message: \_\_ home \_\_ cell \_\_ email

Marital/Partnered Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about Singing Crane Acupuncture? \_\_\_\_\_

1. Are you currently receiving health care? Yes /No If yes, where and from whom?

\_\_\_\_\_

If no, when and where did you last receive health care? \_\_\_\_\_

For what \_\_\_\_\_

2. Has your case been referred to an attorney (Work Comp, personal injury or motor vehicle injury claim, etc.)?  
Yes/ No

3. Please identify your health concerns in order of importance:

Condition	Past Treatment
a. _____	_____
b. _____	_____
c. _____	_____

Patient Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

How do these conditions affect you?

\_\_\_\_\_

What are your goals for the treatment? \_\_\_\_\_

\_\_\_\_\_

4. Are you pregnant or is there any possibility you could be pregnant? Yes/ No

5. Do you have any chronic infectious diseases? Yes/No If yes, please explain:

\_\_\_\_\_

6. Are you currently suffering from any chronic illness? Yes/ No If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

7. Significant diseases, injuries, accidents, hospitalizations, surgeries, scars,  
X-Rays/CAT Scans/MRI/NMR/Special Studies

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Please list any prescriptive medications, over-the-counter medications, vitamins, and supplements that you are currently taking and give your dosage: (Or provide a list of medications)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

9. Please list any foods, drugs, or medications you are hypersensitive or allergic to and please include how it affects you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Height: \_\_\_\_\_ Weight \_\_\_\_\_ Past MaxWeight: \_\_\_\_\_ When? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

11. What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_

When was this reading taken? \_\_\_\_\_ What is your cholesterol? \_\_\_\_\_

12. Immunizations (please circle any that you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis/Diphtheria Hepatitis B

Others: \_\_\_\_\_

13. Family History				
	Mother	Father	Brothers	Sisters
Age if living				
Health (G=good, P=poor)				
Age at death if deceased				
Cause of death				
Check off family illnesses				
Cancer				
Diabetes				
Heart Disease				
Osteoporosis				
High Blood Pressure				
Stroke				
Mental Illness				
Other				

14. Emotional - please put a C for currently experience and P for experienced in the past.

\_\_\_Mood Swings                      \_\_\_Anxiety                      \_\_\_Easily Angered or Agitated  
 \_\_\_Depression                      \_\_\_Mental Tension

Past Traumas \_\_\_\_\_

15. Energy and Immunity - please put a C for currently experience and P for experienced in the past.

\_\_\_Fatigue                              \_\_\_Chronic Infections  
 \_\_\_Slow Wound Healing              \_\_\_Chronic Fatigue Syndrome

16. Head, Eye, Ear, Nose & Throat – please put a C for currently experience and P for experienced in the past.

\_\_\_Ear Ringing                      \_\_\_Sinus Problems  
 \_\_\_Hearing loss                      \_\_\_Hay Fever/Allergies  
 \_\_\_Nose Bleeds                      \_\_\_Blurry or Failing Vision/ Floaters

Patient Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

TMJ/ Jaw Problems                       Headaches  
 Frequent Sore Throat

17. Respiratory - please put a C for currently experience and P for experienced in the past.

Pneumonia     Asthma  
 Frequent Common Colds                       Difficulty Breathing/ Persistent Cough

18. Cardiovascular - please put a C for currently experience and P for experienced in the past.

Heart Disease                       Chest Pain                       Poor Circulation  
 Rapid/Irregular heart beat                       High Blood Pressure                       Ankle Swelling

19. Gastrointestinal - please put a C for currently experience and P for experienced in the past.

Nausea/Vomiting                       Pain over stomach                       Gall Bladder Disease  
 Chronic Diarrhea                       Liver Disease                       Hemorrhoids  
 Chronic Constipation                       Blood in Stool                       Heartburn/Indigestion  
 Excessive Hunger                       Poor Appetite                       Colon trouble  
 Excessive Belching                       Excessive Gas/Bloating                       Difficulty Swallowing  
 Feeling of Food Retention

20. Genito-Urinary Tract - please put a C for currently experience and P for experienced in the past.

Kidney Infection                       Kidney Stones                       Painful Urination  
 Blood/Pus in Urine                       Nighttime urination                       Inability to control urine  
 Decreased Sex Drive

21. Female Reproductive - please put a C for currently experience and P for experienced in the past.

Irregular Cycles                       Bleeding Between Periods                       Vaginal Discharge  
 Previous Miscarriage                       Menopausal Symptoms                       Excessive menstrual flow  
 Extreme Menstrual Pain                       Very Light Menstrual Flow                       PMS  
 Pelvic Pain                       Difficulty conceiving                       Clotting  
 Breast Lumps/Tenderness                       Nipple Discharge                       Chronic Yeast Infections

22. Menstrual/Birthing History

Number of Pregnancies                       Number of Live Births  
 Number of Days of Menses Days in Cycle                       Number of Miscarriages  
 Age of First Period                       Age of last Period  
 Year of Last Pap Smear                       Number of Abortions  
 Type of Birth Control if any

Patient Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

23. Male Reproductive - please put a C for currently experience and P for experienced in the past.

Sexual Difficulties                       Penis Discharge  
 Prostate Problems                       Testicular Pain/Swelling

24. Musculoskeletal - please put a C for currently experience and P for experienced in the past.

Neck/Shoulder Pain/Numbness/Weakness                       Muscle Spasms/Cramps  
 Arm Pain/Numbness/Weakness                       Hand Pain/Numbness/Weakness  
 Leg Pain/Numbness/Weakness                       Hip Pain/Numbness/Weakness  
 Knee Pain/Numbness/Weakness                       Foot Pain/Numbness/Weakness  
 Joint Pain                       Tremors  
 Back Pain/Sciatica

25. Neurological Problems – please put a C for currently experience and P for experienced in the past.

Paralysis                       Numbness                       Loss of Balance  
 Vertigo/Dizziness                       Seizures                       Stroke

26. Endocrine and metabolic disorders: put a C for currently experience and P for experienced in the past.

Hypothyroidism                       Hypoglycemia                       Hyperthyroidism  
 Diabetes Mellitus                       Night Sweats                       Hair Loss

27. Other - please circle any that you experience currently.

Anemia                       Cancer                       Itching/Rashes                       Eczema/Hives  
 Cold Hands/Feet                       Bruise Easily                       Sore that won't heal                       Restless Legs  
 Sudden Weight Loss                       Fainting                       Difficulty to Stop Bleeding                       Brittle Nails  
Other \_\_\_\_\_

28. Lifestyle

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

b. Daily Exercise: \_\_\_\_\_

Sleep: Excellent, Good or Poor                      Number of Hours per Night \_\_\_\_\_  
Regular Dreams: Yes/No                      Regular Nightmares \_\_\_\_\_  
Do you wake feeling rested most mornings? Yes/No

Patient Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

c. Occupation: \_\_\_\_\_ Hours per Week: \_\_\_\_\_

Employer: \_\_\_\_\_ Do you enjoy your work? Yes/No

d. Nicotine and Tobacco Use Per Day: \_\_\_\_\_

e. Caffeine Consumption Per Day: \_\_\_\_\_

f. Alcohol Consumption Per Week: \_\_\_\_\_

g. Marijuana Consumption Per Week: \_\_\_\_\_

h. What do you love to do? \_\_\_\_\_

\_\_\_\_\_

#### 29. One Final Question

Is there anything that I haven't asked you that you think I should know in order to provide you with the best level of care?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_