



BLUE VALLEY PHYSICAL THERAPY
& SPORTS MEDICINE, P.A.

ACUPUNCTURE / ORIENTAL MEDICINE NEW PATIENT INTAKE FORM

Today's Date: _____ Name: _____

Birthdate: _____ e-mail address (our use only): _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone (H): _____ (W): _____ (C) _____

Emergency Contact (Name & Phone): _____

How did you hear about us? _____ Had acupuncture before? Y N When: _____

Reason for visit: _____

How long has this condition existed? _____

Physician (Name & Phone): _____

Other concurrent therapies: _____

Medications: _____

FAMILY MEDICAL HISTORY (CHECK THOSE THAT APPLY)

___ Alcohol/Drug Abuse ___ Cancer ___ Lung Problems ___ Stroke
___ Allergies ___ Heart Problems ___ Seizures ___ Asthma
___ High Blood Pressure ___ Diabetes Other (Specify) _____

YOUR MEDICAL HISTORY: (CHECK THOSE THAT APPLY)

___ Alcohol/Drug Abuse ___ Cancer ___ Lung Problems ___ Stroke
___ Allergies ___ Heart Problems ___ Seizures ___ Asthma
___ High Blood Pressure ___ Diabetes ___ Digestive problems ___ Surgeries/Trauma
Other (Specify) _____

YOUR DIET and CURRENT STATUS

___ High in sugar content (including alcohol) ___ High in caffeine ___ Pregnant/soon
___ High in fat ___ High in fruits & vegetables ___ Bleeding Risk
___ High in salt ___ No meat ___ Seizures