Eva Stanley Acupuncture

1120 W. South Boulder Road, Ste 201-E, Lafayette, CO 80026 | www.evastanley.com | 1502evastan@gmail.com | (970) 808- EASE (3273)

New Patient Intake Form

Patient Information

Date

Full Name
First MI Last

Gender
Male Female

Date of Birth

Social Security #

Address

City State Zip Code

Email

Cell

Home

Work

Martial Status
Single Married Divorced Widowed

# of Children & Ages

Employer

Employment Status
Select Option

Employer Address

City State Zip Code

How did you hear about us?

Whom may we thank for referring you?

Emergency Contact Information

Emergency Contact 1

Name

First Last

Address

City State Zip Code

Phone

Relationship to patient

◯ Parent ◯ Significant Other ◯ Sibling ◯ Child ◯ Friend ◯ Other

Patient Condition

Primary Reason for Care

Secondary Reason for Care

Date Symptoms Started

What are you main treatment goals?

How often do you experience the symptoms?

Constant 100% ◯ Frequent 75% ◯ Intermittent 50% ◯ Occasional 25% ◯ Rare 10% ◯

Are symtoms: ☐ Improving ☐ Progressively Worse ☐ Same

Describe any recent related accident or fall

What makes symptoms increase?

What makes symptoms decrease?

Type of pain:
☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throb ☐ Numbness ☐ Other

Where does the pain radiate to?

How bad is the pain? Indicate "0" no pain to "10" unbearable 0 1 2 3 4 5 6 7 8 9 10

Health & Medical History

What treatment have already received for your condition?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic ☒ None
☐

If so, Name and Address of doctor(s) who have treated you for your condition

Please mark "C" if a current condition, "P" if a past condition and leave blank if not applicable.

- [ ] ADD/ADHD
- [ ] AIDS/HIV
- [ ] Anemia
- [ ] Anorexia
- [ ] Anxiety
- [ ] Appendicitis
- [ ] Arm Pain
- [ ] Arthritis
- [ ] Asthma
- [ ] Bronchitis
- [ ] Bulimia
- [ ] Cancer
- [ ] Carpal Tunnel
- [ ] Celiac Disease
- [ ] Chest Pain
- [ ] Chicken Pox
- [ ] Chronic Fatigue
- [ ] Cold Sores
- [ ] Concussions
- [ ] Cough
- [ ] Chrohn's Disease
- [ ] Depression
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Fainting
- [ ] Fibromyalgia
- [ ] Gall Stones
- [ ] Goiter
- [ ] Gout
- [ ] Headaches
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herniated Disc
- [ ] Herpes
- [ ] High Cholesterol
- [ ] Hypertension
- [ ] Irritable Bowel
- [ ] Infertility
- [ ] Jaw Pain
- [ ] Kidney Infections
- [ ] Kidney Stones
- [ ] Knee Pain
- [ ] Leg Pain
- [ ] Liver Disease
- [ ] Low Back Pain
- [ ] Mid Back Pain
- [ ] Migraine Headaches
- [ ] Miscarriage
- [ ] Mononucleosis
- [ ] Multiple Sclerosis
- [ ] Mumps
- [ ] Neck Pain
- [ ] Night Sweats
- [ ] Numbness/Tingling
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Parkinson's Disease
- [ ] Pinched Nerve
- [ ] Pneumonia
- [ ] Polio
- [ ] Prostate Problems
- [ ] Psychiatric Care
- [ ] Pneumatic Fever
- [ ] Scarlet Fever
- [ ] Sciatica
- [ ] Seizures
- [ ] Shingles
- [ ] Shoulder Pain
- [ ] Sinus Congestion
- [ ] STDs
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tonsilitis
- [ ] Tuberculosis
- [ ] Tumors/Growths
- [ ] Ulcerative Colitis
- [ ] Ulcers
- [ ] Upper Back
- [ ] Urinary Tract Infection
- [ ] Vaginal Infection
- [ ] Whooping Cough

Others Not Listed __________

Allergies:
☐ Dust ☐ Mold ☐ Trees ☐ Weeds ☐ Grass ☐ Animal ☐ Perfume ☐ Smoke ☐ Foods (list on next page)

☐ Other

Description & Dates on the following:

List hospitalizations and/or surgeries you have had.

List recent infections (Cold, Flu, etc)

List any falls and/or injuries

List any fractures and/or dislocations

List current medications

List current vitamins or supplements

Please list your family medical history

Social and Occupational History

Diet

Food Cravings:
☐ Sweets ☐ Salt ☐ Sour ☐ Bitter ☐ Spicy

☐ Alcohol (type/drinks per week)
☐ Sugar (type/amount per day)
☐ Caffeine (type/drinks per day)
☐ Tobacco (type/amount per day)

Typical Breakfast

Mid-Morning Snack

Typical Lunch

Afternoon Snack

Typical Dinner

Typical Beverages

Favorite Foods

Food Allergies?

☐Yes ☐No

Please list food allergies

Female Only

Total Length of Cycle

Length of Menses

Menses:

☐Heavy ☐Moderate ☐Light ☐PMS ☐Mood Swings ☐Cramping ☐Breast Tenderness ☐Pregnant ☐Post Menopausal

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Gastrointestinal

☐Excess Hunger ☐Poor Appetite ☐Nausea ☐Hemorrhoids ☐Diarrhea ☐Constipation ☐Heartburn ☐Gas ☐Bloating ☐Strong Smell

#Bowel Movements/Day

Sleep: hours per night

Quality of Sleep

☐Poor ☐Fair ☐Good ☐Trouble Falling Asleep ☐Staying Asleep ☐Insomnia

What time do you wake up?

How many times do you wake up?

Night Urination: How many times?

Do you sleep on your:

☐Back ☐Side ☐Stomach ☐All

Urination

☐Excess Urination ☐Frequent Urination ☐Painful Urination

Job Activities Include:

Physical Activity at Work

☐Sedentary ☐Light Manual Labor ☐Moderate Manual Labor ☐Heavy Manual Labor

How long do you speak on the telephone each day?

☐Traditional Phone ☐Headset

Do any of your work activities aggravate your present main compliants? Please describe.

Stress Level:

☐Mild ☐Medium ☐Severe

Reason