

Andrew Macfarlane MS, Licensed Acupuncturist

New Patient Intake Form

*Please print clearly and bring with you to the office for your first appointment.
All records are confidential.*

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____ Gender: _____

Telephone # (home): _____ (work): _____

(cell): _____ E-Mail: _____

Occupation: _____

Married ___ Separated ___ Divorced ___ Widowed ___ Single ___ Partnership _____

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone _____

Emergency Contact (name, number, and relationship): _____

How did you hear about Andrew Macfarlane MS, L.Ac. ? _____

Primary Care Physician: _____ Number: _____

Chief Complaint (reason for visit): _____

Are you currently receiving healthcare? _____

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Name _____ Date _____

If yes, where and from whom? _____

If no, when and where did you last receive healthcare? _____

What was the reason? _____

List all previous treatments for your chief complaint (including medications): _____

Other Current Medical Conditions/ Concerns: _____

Current Medications (including over the counter), Vitamins, Supplements, Herbs:

Do you have any known contagious diseases at this time? _____

If yes, what? _____

Family History: (list major medical conditions)

Father _____

Mother _____

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Name _____ Date _____

Siblings _____

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Name _____ Date _____

Past Medical History: Check any of the following you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

AIDS/HIV _____	Diabetes _____	Multiple Sclerosis _____
Alcoholism _____	Emphysema _____	Mumps _____
Allergies _____	Epilepsy _____	Pacemaker _____
Appendicitis _____	Goiter _____	Pleurisy _____
Arteriosclerosis _____	Gout _____	Pneumonia _____
Asthma _____	Heart Disease _____	Polio _____
Birth Trauma _____	Hepatitis (type) _____	Rheumatic Fever _____
(your own birth)	Herpes (oral/genital) _____	Scarlet Fever _____
Cancer _____	High Blood Pressure _____	Seizures _____
Chicken Pox _____	Measles _____	Stroke _____
Chest Pain _____	Glaucoma _____	
Depression _____		

Surgery (list/ include dates) _____	Thyroid Disorders _____
_____	Tuberculosis _____
_____	Typhoid Fever _____
_____	Ulcers _____
_____	Venereal Disease _____
_____	Whooping Cough _____

Major Trauma (list/ include dates) _____

Other (specify) _____

General:

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight: _____ When: _____

Life Style:

Do you smoke? _____ Cigarettes _____ Pipe _____ Cigars _____
of years? _____ How much? _____ When Quit? _____

Do you drink alcohol? _____ Do you use street drugs? _____

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What type? _____ What type? _____
How much? _____ How much? _____
How often? _____ How often? _____

Have you been treated for alcohol and/or drug dependence? _____ When? _____

Do you have a supportive relationship? Yes: _____ No: _____

Do you have a history of abuse? Yes: _____ No: _____

of hours of sleep per night: _____ Bedtime: _____ Awaken: _____

Are you under a lot of pressure at work? Yes: _____ No: _____

Do you exercise? _____ Type: _____ Frequency: _____

Do you have a religious/ spiritual practice? _____

Diet: Describe your typical diet. Include eating times.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Dietary Restrictions: _____

Food Allergies: _____

Food Cravings: _____

Do you eat late at night, or close to bedtime? _____

Do you drink water? _____ Type: _____ Glasses per day: _____

Do you regularly drink coffee? _____ How many cups per day? _____

Do you regularly drink caffeinated tea? _____ How many cups per day? _____

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Name _____ Date _____

Do you regularly drink cola/ soda? _____ How many cups per day? _____

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Name _____

Date _____

General Symptoms: Please check all that apply.

	Current	Past
• poor / increased appetite	_____	_____
• weight loss / gain	_____	_____
• fatigue	_____	_____
• irritable / depressed/ anxious	_____	_____
• prefer hot / cold drinks	_____	_____
• sweat easily	_____	_____
• night sweating	_____	_____
• fever / chills	_____	_____
• cold hands & feet	_____	_____
• poor circulation	_____	_____
• numbness & tingling in hands / feet	_____	_____
• muscle cramps / weakness	_____	_____
• bruise easily / bleed	_____	_____
• dry skin	_____	_____
• itchy skin	_____	_____
• rashes / eczema / psoriasis / acne	_____	_____
• headache / migraine	_____	_____
• dizziness / vertigo	_____	_____
• blurred vision	_____	_____
• eye pain / tear / red / itch	_____	_____
• facial pain	_____	_____
• sinus disorder / pain / pressure	_____	_____
• runny nose	_____	_____
• swollen glands	_____	_____
• sore throat	_____	_____
• difficulty swallowing	_____	_____
• decreased hearing	_____	_____
• ringing in ears	_____	_____
• gum / teeth problems/ grinding	_____	_____
• hair loss	_____	_____
• shortness of breath	_____	_____
• chest tightness/ pain	_____	_____
• asthma / wheezing	_____	_____

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412-242-4220

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Name _____

Date _____

- cough
dry/ hacking
color of phlegm
copious/sticky/blood

_____	_____
_____	_____
_____	_____
_____	_____

General Symptoms cont'd.

Current

Past

- environmental allergies
- palpitations
- irregular heart beat
- low blood pressure
- high blood pressure

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- indigestion
- gas / flatulence
- bloating
- belching / burping
- acid regurgitation
- nausea / vomiting
- foul breath
- diarrhea
- loose stools
- constipation
- blood / mucous in stools
- intestinal cramping
- hemorrhoids

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

- frequent urination
- urgent urination
- blood in urine
- pain / burning urination
- cloudy urination
- incontinence
- night urination
- urinary infections

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

- neck / shoulder pain
- upper back pain
- lower back pain
- rib pain
- difficulty falling asleep
- awaken at night

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

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Name _____

Date _____

- nightmares _____

GYNECOLOGY (women):

- age of onset for menses _____

• date of last pap smear _____

results _____

• date of last menstrual period _____

• length of cycle (regular / irregular) _____

• duration of flow _____

- color of flow _____

• do you have clots with menstrual flow? _____

• menstrual pain / cramping _____

location _____

- any vaginal discharge _____

- history of urinary tract infections? _____

• uterine fibroids _____

type _____

• ovarian cysts _____

• PMS

• breast tenderness _____

• mood changes (type) _____

• bloating _____

• headache _____

location _____

• low back pain _____

• food cravings _____

• method of contraception _____

• age of menopause _____

Are you currently pregnant? _____

Number of pregnancies _____

Number of abortions/ miscarriages _____

UROLOGY (men):

• date of last prostate exam _____

results _____

• urinary frequency _____

• poor stream flow _____

• premature ejaculation _____

- erectile dysfunction _____

Additional Information _____

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Name _____ Date _____

Notice: Individuals with bleeding disorders, medical or aesthetic implants, and/or cancer: For your safety it is vital to alert the acupuncturist of these conditions.

Signature _____ Date _____

Print Name _____

Andrew Macfarlane MS, L.Ac

Dear New Patient,

Welcome to our Center. We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care. Please initial the following lines.

_____ Payment for all services and products is due at the time of the visit.

_____ We do not currently accept insurance.

_____ You will be charged the full cost of your appointment for any missed appointments or late cancellations (less than 24 hours notice).

_____ I give permission for the staff at Pittsburgh Center for Complementary Health and Healing to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.

_____ I have read and agree to Andrew Macfarlane's L.Ac Privacy Practices

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Discover, Debit cards, checks, and cash. There will be a charge of \$20.00 for every returned check(s).

I have read and understand the above-stated policies and will comply with them in all respects.

Print your name

Signature

Date

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Name _____ Date _____

Andrew Macfarlane MS, L.Ac
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