Anchor Flow Acupuncture PLLC

Rupali Jain, L.Ac., Dipl. O.M. (NCCAOM)
(512) 660-7055 • info@anchorflowacu.com • anchorflowacu.com

New Patient Intake Form

Welcome to Anchor Flow Acupuncture. Please complete this form before your first visit — everything you share is confidential and becomes part of your clinical record. If a question doesn't apply to you, simply leave it blank.

TODAY'S DATE | FIRST APPOINTMENT DATE (IF KNOWN) | CHART # (OFFICE USE)

1 Patient Information

LEGAL LAST NAME | FIRST NAME | MIDDLE INITIAL | PREFERRED NAME

DATE OF BIRTH | AGE | HEIGHT | WEIGHT | PRONOUNS (OPTIONAL)

STREET ADDRESS

CITY | STATE | ZIP CODE | PREFERRED LANGUAGE

CELL PHONE | HOME PHONE | WORK PHONE

EMAIL ADDRESS | OCCUPATION

Sex / gender — *check one*

☐ Female ☐ Male ☐ Another identity ☐ Prefer not to say

WHO DO YOU LIVE WITH? (INCLUDE CHILDREN, FAMILY, PETS) | REFERRED BY (NAME, IF A PERSON REFERRED YOU)

PRIMARY CARE PHYSICIAN | PHYSICIAN PHONE

Best way to reach you — *check all that apply*

☐ Phone call ☐ Text message ☐ Email ☐ Patient portal

If we can't reach you, may we leave a message (voicemail, or with someone in your home)? — *check one*

☐ Yes, you may leave a message ☐ No, please do not leave messages

May we call you at work if needed? — *check one*

☐ Yes, you may call me at work ☐ No, do not call me at work

How did you hear about us? — *check one*

☐ Internet / Google search ☐ Friend or family member ☐ Another healthcare provider
☐ Social media ☐ Drove by / saw the clinic ☐ Other

2 Emergency Contact

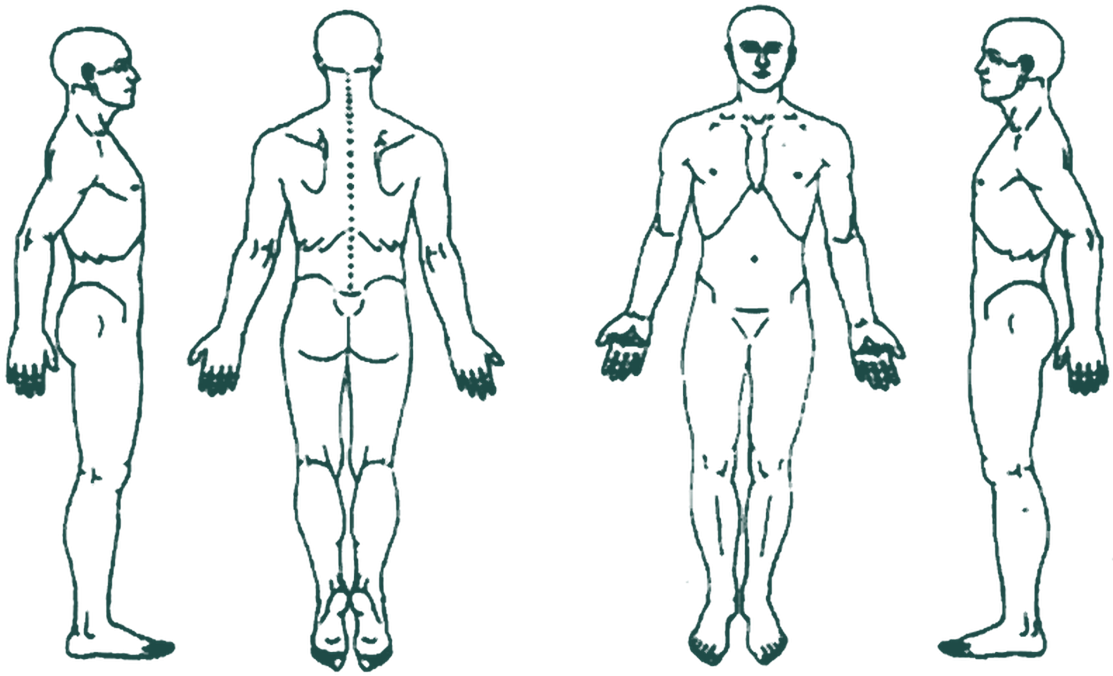
EMERGENCY CONTACT NAME | RELATIONSHIP TO YOU | PHONE

☐ I authorize Anchor Flow Acupuncture PLLC to contact this person about my care in an emergency.

3 Reason for Your Visit

Where is it? — mark the body charts

On the figures below — front, back and both sides — draw an **X** where you feel pain, shade any areas that ache or feel tight, and write **N** anywhere you feel numbness or tingling. If you're completing this form on a computer, describe the spots in the notes field under the charts instead.



RIGHT SIDE BACK FRONT LEFT SIDE

YOUR MAIN CONCERN — IN YOUR OWN WORDS (AND ANY OTHER CONCERNS)

About your main concern

CONCERN	WHEN DID IT START?	HOW OFTEN DOES IT OCCUR?	SEVERITY (MILD / MODERATE / SEVERE)

Pain assessment — if pain is part of your concern

Pain right now ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 — 0 = no pain, 10 = worst imaginable

How often do you feel it? — *check one*

☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally ☐ None

What does it feel like? — *check all that apply*

☐ Sharp ☐ Dull / achy ☐ Burning ☐ Stabbing ☐ Numb / tingling

NOTES ABOUT THE MARKED AREAS (WHICH SPOTS, SINCE WHEN, HOW IT FEELS)

WHAT MAKES IT BETTER?

WHAT MAKES IT WORSE?

TREATMENT YOU'VE ALREADY TRIED FOR THIS — AND WHAT HELPED

RECENT LABS OR IMAGING (TYPE & DATE, IF ANY)

WHAT DO YOU HOPE TO ACHIEVE WITH CARE AT ANCHOR FLOW?

4 Medical History

Check every condition you have been **diagnosed with** or currently experience:

- ☐ Diabetes / pre-diabetes
- ☐ Stroke / TIA
- ☐ COPD / breathing problems
- ☐ Cancer
- ☐ Liver disease / hepatitis
- ☐ Migraines / headaches
- ☐ Anxiety
- ☐ Pacemaker / implants
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Autoimmune condition
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Seizures / epilepsy
- ☐ Anemia
- ☐ Heart disease
- ☐ Asthma
- ☐ Thyroid disorder
- ☐ Osteoporosis
- ☐ Digestive disorder (IBS, IBD, reflux)
- ☐ Depression
- ☐ Bleeding / clotting disorder

Conditions in more detail (if applicable)

CONDITION	DIAGNOSED (MONTH / YEAR)	TREATED BY (PROVIDER)	WELL CONTROLLED? (Y / N)

Significant past illnesses, infections or injuries

ILLNESS / INJURY	WHEN (YEAR, OR START–END)	TREATMENT & OUTCOME

Surgeries, procedures & hospitalizations

PROCEDURE / REASON	YEAR	PERFORMED BY / WHERE

ALLERGIES — MEDICATIONS, FOODS, LATEX, ENVIRONMENTAL (AND YOUR REACTION)

- ☐ I am currently pregnant, or there is a chance I could be pregnant.
- ☐ I am currently trying to conceive.

5 Medications, Supplements & Herbs

Please list **everything** you take — some herbs and medicines don't mix well.

PRODUCT / MEDICATION	TYPE (RX / OTC / HERB / SUPPLEMENT)	DOSE	HOW OFTEN	SINCE

6 Family History

Tick the box for each condition in your immediate family.

	FATHER	MOTHER	BROTHER(S)	SISTER(S)	GRANDPARENTS
Diabetes	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer (note type below)	☐	☐	☐	☐	☐
Mental health condition	☐	☐	☐	☐	☐

IF A CLOSE RELATIVE HAS PASSED AWAY — WHO, AT WHAT AGE, AND CAUSE (IF KNOWN)

7 Lifestyle & Daily Habits

Movement & exercise

EXERCISE — TYPE(S), HOW OFTEN, FOR HOW LONG

HOURS OF SCREEN TIME PER DAY (WORK + LEISURE)

Sleep, energy & stress — the past week

AVERAGE HOURS OF SLEEP PER NIGHT

STRESS LEVEL, 0–10 (0 = NONE, 10 = EXTREME)

ENERGY LEVEL, 0–10 (0 = EXHAUSTED, 10 = EXCELLENT)

SLEEP QUALITY / PROBLEMS (TROUBLE FALLING ASLEEP, WAKING AT NIGHT, VIVID DREAMS…)

Eating, appetite & thirst

DESCRIBE A TYPICAL DAY OF EATING

FOODS YOU AVOID, ARE SENSITIVE TO, OR CRAVE

Habits — how much, honestly (it affects your treatment plan)

	NONE	LIGHT	MODERATE	HEAVY	AMOUNT / COMMENTS
Alcohol	☐	☐	☐	☐	
Coffee	☐	☐	☐	☐	
Tobacco / nicotine	☐	☐	☐	☐	
Cannabis	☐	☐	☐	☐	

8 Review of Systems

check anything experienced in the last 3 months

GENERAL & SKIN

- ☐ Poor appetite
- ☐ Change in appetite
- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Fatigue
- ☐ Night sweats
- ☐ Rashes
- ☐ Itching
- ☐ Eczema / psoriasis
- ☐ New or changing moles

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Blurry vision
- ☐ Dry eyes
- ☐ Spots / floaters in vision
- ☐ Ringing in ears (high-pitched)
- ☐ Ringing in ears (low-pitched)
- ☐ Sinus problems

HEART, LUNGS & CIRCULATION

- ☐ Chest pain / pressure
- ☐ Palpitations
- ☐ Irregular heartbeat

- [ ] Fainting
- [ ] Cold hands & feet
- [ ] Swelling of hands / feet
- [ ] Blood clots
- [ ] Cough
- [ ] Shortness of breath

DIGESTION (GASTROINTESTINAL)

- [ ] Nausea
- [ ] Vomiting
- [ ] Heartburn / reflux
- [ ] Bloating
- [ ] Gas
- [ ] Abdominal pain / cramps
- [ ] Diarrhea
- [ ] Constipation
- [ ] Blood in stools

URINARY & REPRODUCTIVE

- [ ] Frequent urination
- [ ] Urgency to urinate
- [ ] Pain on urination
- [ ] Blood in urine
- [ ] Difficult / incomplete urination
- [ ] Unable to hold urine
- [ ] Kidney stones
- [ ] Low libido
- [ ] Wake at night to urinate

MUSCLES, BONES & JOINTS

- [ ] Neck pain
- [ ] Shoulder pain
- [ ] Back pain
- [ ] Hip pain
- [ ] Knee pain
- [ ] Hand / wrist pain
- [ ] Foot / ankle pain
- [ ] Joint stiffness

MIND, NERVES & MOOD

- [ ] Easily stressed
- [ ] Anxiety
- [ ] Depression
- [ ] Bad temper / irritability
- [ ] Easily startled
- [ ] Difficulty concentrating

ANYTHING ELSE ABOUT YOUR BODY OR HEALTH THAT WE HAVEN'T ASKED?

9 East Asian Medicine Review

check all that sound like you

TEMPERATURE & SWEATING

- [ ] Feel cold easily
- [ ] Feel warm / hot easily
- [ ] Night sweating

DIGESTION, THIRST & BOWELS

- [ ] Bowel movement daily
- [ ] Loose / unformed
- [ ] Dry, hard or pellet-shaped
- [ ] Feel there's still more (incomplete)
- [ ] Mouth often feels dry
- [ ] Bitter taste in the mouth

ENERGY, MOOD & STRESS

- [ ] Feel stressed or anxious
- [ ] Sighing often — sighing feels good
- [ ] Tight or full feeling in the chest
- [ ] Lump-in-the-throat feeling
- [ ] Tired after eating (esp. carbs / sugar)
- [ ] Bruise easily

PAIN & CIRCULATION PATTERNS

- [ ] Fixed, sharp pain anywhere
- [ ] Pain worse in the evening / night
- [ ] Numbness in hands or feet

10 Menstrual & Gynecological History

complete if applicable

AGE AT FIRST PERIOD

FIRST DAY OF LAST PERIOD (LMP)

CYCLE LENGTH (DAYS, FIRST DAY TO FIRST DAY)

HOW MANY DAYS OF BLEEDING?

FLOW (LIGHT / MODERATE / HEAVY)

About your cycle — *check all that apply*

- [ ] Irregular cycle
- [ ] Painful periods / cramps
- [ ] Premenstrual symptoms (PMS)

NUMBER OF PREGNANCIES

BIRTHS

MISCARRIAGES

ABORTIONS

BIRTH CONTROL — TYPE & HOW LONG USED

MENOPAUSE (IF APPLICABLE)

- [ ] I am post-menopausal.

AGE AT MENOPAUSE

HORMONE THERAPY — TYPE & SINCE WHEN