

915 W. Northern Lights Blvd.
Anchorage, AK 99503

Avante Medical Center
Acupuncture Dept.

t. 907-770-6700
f. 907-770-6707

NEW PATIENT INTAKE FORM

Confidential Introductory Patient Information

Today's Date: _____

Name: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Business Phone: (____) _____ Fax: (____) _____

City: _____ State: _____ Zip: _____ Email Address: _____

Birth date: _____ Gender: _____ Number of Children: _____ Ages: _____

Occupation: _____ Contact in emergencies: _____ Phone: _____

Referred by: _____

Insurance Information (if applicable – Oxford, United Healthcare, PHCS)

Insurance Provider: _____

Provider's Address and Phone: _____

Social Security Number: _____ Member ID: _____ Group ID: _____

Employer (Name and Address): _____

Insured's Name and Date of Birth (if other than patient): _____

Primary complaint:

How long have you had this condition? _____

Secondary complaint: _____

How long have you had this condition? _____

Please list any medications, herbs, or supplements you are currently taking, whether prescription or nonprescription: _____

Serious Illnesses/Injuries/Surgeries/Hospitalizations	Dates	Outcome

	Allergies/Sensitivities (please specify)	Typical Reaction
	Pollen	
	Medications	
	Animal hair	
	Dust, molds	
	Food	
	Other	

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Please check all that apply to you:

<input type="checkbox"/> Frequent childhood illness	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Headaches	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Frequent colds or sore throat	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Urinary difficulty
<input type="checkbox"/> Allergies	<input type="checkbox"/> Itching	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Urinary frequency
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Hives	<input type="checkbox"/> Hepatitis A/B/C	<input type="checkbox"/> Sugar cravings
<input type="checkbox"/> Lymph nodes enlarged	<input type="checkbox"/> Eczema	<input type="checkbox"/> Venereal diseases	<input type="checkbox"/> Food cravings
<input type="checkbox"/> Lymph nodes removed	<input type="checkbox"/> Acne	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Excess appetite
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Reduced appetite
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Excess weight gain	<input type="checkbox"/> Bloating	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Excess sweating
<input type="checkbox"/> Excess weight loss	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hiatal hernia	<input type="checkbox"/> Numbness
<input type="checkbox"/> Intestinal gas	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Excess thirst	<input type="checkbox"/> Muscle spasms
<input type="checkbox"/> Aches/pains	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Premature greying	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Nails brittle	<input type="checkbox"/> Sad/depressed
<input type="checkbox"/> Cold body temperature	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Forgetful	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Hot body temperature	<input type="checkbox"/> Hair dry or brittle	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Irritability
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Seeing spots	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Rapid heartbeat or palpitations	<input type="checkbox"/> Cold sores	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Clogged/popping ears
<input type="checkbox"/> Water retention	<input type="checkbox"/> Dental problems	<input type="checkbox"/> Eye pain, redness, dryness, or itching	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Hypotension
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Heart conditions, please specify:	<input type="checkbox"/> Blood Pressure: /
			<input type="checkbox"/> Other: <input type="checkbox"/> Latex allergy

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Men:

Check all that apply:

- Prostatitis Impotence
 Other, please specify: _____

Women:

At what age did you start menstruating? _____ Age at menopause (if applicable) _____

Number of days between cycles: _____

Number of days of flow: _____ Color: _____

Check all that apply:

<input type="checkbox"/> Heavy flow <input type="checkbox"/> Light flow	<input type="checkbox"/> Hormone replacement <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Menopausal symptoms, please specify: _____ _____ _____
<input type="checkbox"/> No flow <input type="checkbox"/> Spotting between periods	<input type="checkbox"/> PMS symptoms, please specify: _____ _____	<input type="checkbox"/> Other, please specify: _____ _____
<input type="checkbox"/> Discomfort or pain before period <input type="checkbox"/> Discomfort of pain during period	<input type="checkbox"/> Birth control, please specify: _____ _____	

Number of pregnancies: _____ Number of deliveries: _____

Family Medical History (Please list any significant family illnesses)

Mother _____

Father _____

Siblings _____

Grandparents _____

On the following drawing, please shade the areas that you would like addressed:

