

Clancy Acupuncture & Oriental Medicine
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1905 Baywood Drive
Sarasota, Florida 34231
(502) 710-9088

NEW PATIENT INTAKE FORM

****Patient Information****

Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact (Name & Phone): _____

****Chief Complaint****

Reason for visit: _____

Duration of condition: _____ Severity (1–10): _____

What improves it? _____ What worsens it? _____

Yes No — Previous acupuncture/herbal medicine experience

****Medical & Family History****

Current Medications: _____

Supplements/Vitamins: _____

Allergies (drug, food, environmental): _____

Past Medical History (check all that apply):

Diabetes Heart disease High blood pressure Stroke Cancer _____

Seizures Thyroid disorder Depression/Anxiety Asthma Other _____

Family History (check all that apply):

Diabetes Heart disease High blood pressure Stroke Cancer _____

Mental illness Thyroid disorder Other _____

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****Lifestyle & TCM Health Patterns****

Sleep: Quality _____ Hours/night _____ Night waking? Yes No

Digestion: Appetite Low Normal High Bowel movements: _____

Energy: Fatigue Low stamina Better in morning Better in evening

Emotions: Stress Anxiety Irritability Sadness Depression

Environmental sensitivity: Heat Cold Damp Wind

Exercise type/frequency: _____

Habits: Alcohol Tobacco Caffeine Marijuana/Drugs

Women's Health (if applicable):

Age at first menses: ____ Cycle length: ____ days Flow: Light Moderate Heavy

Symptoms: PMS Cramps Clots Hot flashes Night sweats

Pregnancies: ____ Births: ____ Miscarriages: ____ Date of last period: _____

****Symptom Checklist****

Cardiovascular: Chest pain Palpitations Fainting High BP Low BP

Respiratory: Cough Shortness of breath Asthma Wheezing Phlegm _____

Gastrointestinal: Nausea Vomiting Bloating Constipation Diarrhea Acid reflux

Musculoskeletal: Joint pain Back pain Neck/shoulder pain Limited mobility

Skin & Hair: Rashes Hives Itching Eczema Psoriasis Acne

Dandruff Dry skin Hair loss Change in hair/skin texture Fungal infections

Other: _____

Neurological: Headaches Migraines Dizziness Seizures Numbness

****TCM Patterns****

Sweating: None Spontaneous Night sweats

Temperature: Cold Hot Alternating

Thirst: None Excessive Preferred fluids: Cold Warm

Pain: Dull Sharp Burning Moving Fixed Other _____

Other concerns: _____