

IVY TCM

NEW PATIENT INTAKE & HEALTH HISTORY

Patient information, concerns & safety screening

1928 Proctor Ave, Orlando, FL 32817 | 646-773-0520 | IVYTCM@outlook.com

Print clearly. Write N/A if not applicable. You may discuss sensitive questions privately or attach additional information.

1 PATIENT INFORMATION

Legal name: Preferred name: DOB:

Address / city / state / ZIP:

Phone: Email: Today's date:

Occupation: Language / interpreter or access needs:

☐ Preferred contact: Phone ☐ Email ☐ Discuss privately ☐ Self-pay ☐ Insurance inquiry ☐ Superbill

Emergency contact: Relationship: Phone:

An emergency contact listing does not authorize routine release of health records.

Primary / other treating clinician: Phone: Last visit:

2 MAIN CONCERNS & GOALS

Main concern, body area / side, onset, and possible trigger:

Frequency: Better / worse with:

Prior tests, diagnoses, treatments, and response:

Pain (0 = none; 10 = worst imaginable): Now Usual Worst [Leave blank if not applicable]

Effect on sleep / work / movement:

Treatment goals / other concerns:

Previous acupuncture? Yes / No Response or problems:

3 SAFETY SCREENING - MARK ONE ANSWER PER ROW

	Yes	No	Unsure
Bleeding disorder, low platelets, easy bruising, or blood-thinning medication?	☐	☐	☐
Pacemaker, defibrillator, or other implanted electronic device?	☐	☐	☐
Pregnant, possibly pregnant, or trying to conceive?	☐	☐	☐
Seizures, fainting with needles, or significant needle anxiety?	☐	☐	☐
Fever, infection, open wound, skin problems, or poor wound healing?	☐	☐	☐
Reduced sensation / neuropathy, immune suppression, or chemotherapy?	☐	☐	☐
Recent surgery, hospital stay, or major health change?	☐	☐	☐
Explain Yes / Unsure answers (attach details if needed):			

CONFIDENTIAL | Please return directly to the clinic.

1 / 2

Patient name: _____ DOB: _____

4 ALLERGIES, MEDICINES & SUPPLEMENTS

☐ Allergies: None known ☐ Yes ☐ Unsure ☐ Additional list attached

Allergen / product and reaction (include medicines, herbs, metals, latex, adhesives, foods):

List prescriptions, OTC medicines, vitamins, herbs and supplements. Attach a complete list if needed.

Name / product	Dose / frequency	Reason / notes

☐ No current medicines or supplements ☐ Additional medication list attached ☐ Will bring list

5 MEDICAL & FAMILY HISTORY - CHECK CURRENT OR PAST CONDITIONS

☐ Heart / rhythm disorder ☐ High blood pressure ☐ Diabetes ☐ Stroke / clot

☐ Lung / asthma ☐ Kidney / liver ☐ Cancer ☐ Thyroid ☐ Arthritis / chronic pain

☐ Migraines ☐ Digestive condition ☐ Anxiety / depression ☐ Other ☐ None known

Details / dates, surgeries, hospitalizations, relevant family history: _____

6 DAILY WELL-BEING

Sleep: _____ hours/night; quality / concerns: _____ Energy (0 low - 10 high): _____

Stress (0 none - 10 high): _____ Appetite / diet / restrictions: _____

Digestion / bowel / urinary concerns: _____

Exercise / movement: _____ Water / caffeine intake: _____

Alcohol / tobacco / vaping / cannabis / other substances (amount / frequency): _____

Reproductive / menstrual / pregnancy / menopause concerns, if applicable: _____

Other concerns / comfort needs: _____

7 CONFIRMATION & CLINIC REVIEW

To the best of my knowledge, this information is accurate. I will report changes to my practitioner. This form is not treatment consent or authorization to disclose health information.

Patient / representative signature: _____ Date: _____

Representative name / legal authority (if applicable): _____

Clinician reviewed by: _____ Date: _____ Follow-up: _____