Intake Form

Confidential Patient Information
Your information will not be shown to anyone without your consent.

Please print the following information:

Name_____Date_____

Street_____City_____

State_____Zip_____E-mail_____

Home Phone_____

Business Phone_____

Birthday_____Place of Birth_____

Time of Birth (estimate):_____

Occupation_____Employer_____

Emergency Contact_____ Phone_____

Family Physician_____

Referred by_____

MEDICAL HISTORY

Have you had acupuncture before? Yes / No Herbal medicine? Y / N

Do you currently have any infectious disease? Y / N If yes, please identify: ___HIV+

___ Hepatits B ___Hepatitis C ___Mononucleosis ___Tuberculosis ___Streptococcus

Reason(s) for this visit_____

When did this

begin?_____

Rate the severity of the main complaint (1=mild, 10=severe) 1 2 3 4 5 6 7 8 9 10

Do you receive treatments for this/these conditions from other practitioners? Y / N

If yes, who?

_____Phone:_____

Known or suspected allergies:_____

Cardiovascular	**Psychological**	**Energy & Immunity**	**Respiratory**
__Heart disease __Pacemaker __High blood pressure __Low blood pressure __Chest pain __Palpitations __Stroke __Varicose veins __Edema __Hemophilia	__Clinical depression __Mild depression __ADD or ADHD __Schizophrenia __Mood swings __Panic attacks __Nervousness __Anxiety __Alzheimer's __Dementia __Substance abuse	__Chronic fatigue syndrome __General fatigue __Slow wound healing __Easy bruising __Chronic infections __Frequent allergies __Anemia	__Pneumonia __Asthma __Frequent infections __Difficulty breathing __Emphysema __Persistent cough __Pleurisy __Tuberculosis __Breath shortness __Hoarse voice __Weak voice
Musculoskeletal	**Head**	**Urinary**	**Gastrointestinal**
__Neck pain __Shoulder pain __Upper back pain __Midback pain __Lumbar pain __Leg pain __Muscle pain __Muscle cramps __Muscle twitches or spasms __Osteoporosis __Arthritis __Other joint pain	__Impaired vision __Eye pain/strain __Glaucoma __Glasses/contacts __Excess tears __Eyes dry __Hearing impaired __Ears ringing __Earaches __Ear infections __Headaches __Sinus problems __Nose bleeds __Teeth grinding __Frequent sore throat ___TMJ / jaw problems __Hay fever	__Kidney disease __Kidney stones __Painful urination __Dribbling urination __Frequent UTI __Frequent urination __Blood in urine __Discharge __Incontinence __Night-time urination How many times?____	__Stomach ulcers __Appetite low __Constant hunger __Nausea / vomiting __Epigastric/ abdominal pain __Passing gas __Acid reflux __Belching __Gall bladder disease __Gall bladder stones __Hemorrhoids __BM < once daily __Hard stools __Diarrhea __Inflamed bowel __Irritable bowel
Endocrine	**Neurological**	**Skin**	**Other**
__Hypothyroid __Hyperthryoid __Diabetes type I __Diabetes type II Other_____	__Vertigo/ dizziness __Paralysis __Numbness/tingling __Loss of balance __Seizures	__Eczema __Psoriasis __Acne __Dry skin	__Cancer Type:_____ __Autoimmune Type:_____

Female ____Perimenopause ___Postmenopause Pregnancy: __Now __Trrying __Maybe Birth Control Method_____ Age of First Menses_____ Date of Last Menses_____ Cycle length (days)_____ Average length of menses (days)_____ No. of: Pregnancies____ Births_____ Abortions_____ Miscarriages____ Hysterectomy Y / N Date:_____ Check All That Apply: ___Clots __Painful Periods __Heavy Flow __Scanty Flow __Painful Intercourse __Unexpected Bleeding __Irregular Cycles __Vaginal discharge __Breast Tenderness or Lumps __Nipple Discharge __Infertility __PMS	**Male** __Impotence __Vasectomy __Prostate problems __Painful intercourse __Seminal emissions __Testicular pain

PAIN

Please answer the following questions if you have pain. Indicate location of pain on diagram.

Quality of pain: __Dull __Sharp __Stabbing __Sore __Cramping __Burning __Fixed __Moves __Constant __Comes and goes Rate on scale of 1-10 (10=worst)_____

Does the pain radiate? Y / N

Where?_____

What reduces the pain? __Cold __Heat __Rest __Movement __Pressure / Massage __Moisture __Nothing

What increases the pain? __Cold __Heat __Rest __Movement __Pressure / Massage __Moisture __Nothing

Thermal	**Sweating**	**Thirst**
__Feel hotter than others __Feel colder than others __Hot flashes __Cold hands __Cold feet __prefer cold or cool beverages __prefer neutral beverages __prefer warm or hot beverages	__Spontaneous sweating __Excessive sweating __Night sweating __Insufficient sweating	__0-4 cups of fluid daily __4-8 cups of fluid daily __about 8 cups daily __8-12 cups daily __12-16 cups daily __drink in sips __drink in gulps

Appetite	**Bowel Movements**	**Emotions**
__Good appetite __Weak appetite __Cravings for __Sweet __Salty __Sour __Spicy __Bitter __Other_____	__Soft or loose stool __Hard stool __Alternating stool consistency __BM < 3 times weekly __BM 3-5 times weekly __BM 6-7 times weekly __BM 2-3 times daily __BM > 3 times daily	I frequently feel: __Angry __Joy __Irritable __Fear __Impatient __Timid/shy __Anxiety __Indecisive __Worry __Obsessive __Sadness __Grief __Depression

MEDICATIONS

Please list the medications and supplements you currently take:

Drug or supplement Reason for use For how long Dose Frequency

_____

_____

_____

_____

_____

_____

Do you take Coumadin / Warfarin? Y / N

LIFESTYLE

Daily amount used within the last 2 months

___Tobacco Amount:_____ ___Alcohol Amount:_____

___Coffee Amount:_____ ___Recreational drugs Amt:_____

___Soda Amount:_____ ___Sugar / sweets Amount:_____

___TV Amount:_____

Hours of sleep per night:_____

Please provide any information you wish to share that might not have been covered by the above questions:

Signature _____Date_____