

Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential.

GENERAL INFORMATION

Name _____ Gender M F Date _____

Address _____ City _____ State _____ Zip _____

Email _____

Phone: Home _____ Work _____ Cell _____
(please indicate preferred contact number)

Single Married Partnered Widowed Separated/Divorced

Occupation _____ Employer _____

Date of Birth _____ Age _____ Height _____ Weight _____

Emergency contact _____ Relation _____

Emergency contact number: Home _____ Cell _____

Who can we thank for referring you? _____

Name of physician _____ Phone number _____
(No contact will be made without your permission)

Your signature _____ Have you received acupuncture previously? Yes No

WHAT BRINGS YOU HERE

What health concerns bring you into our office for treatment? _____

When did you first notice your symptoms? _____

What other forms of treatment have you sought? _____

LIFESTYLE HABITS

Alcohol (drinks per week) _____ Coffee/Tea (cups per day) _____ Soda (regular or diet) _____

Cigarettes (packs per day) _____ Drug use (recreational) _____

What does your diet consist of? _____

List any allergies, food sensitivities or food cravings that you have: _____

Exercise Yes No How often? _____

What kind of exercise? _____

FAMILY HISTORY — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self	mother	father	sibling	spouse/partner	children
Adopted						
Good Health						
Alcohol or other drug use						
Depression or mental illness						
Allergies						
High blood pressure/heart disease/stroke						
Cancer or tumors						
Diabetes						
Seizures						
Hepatitis/other liver disorder						
HIV/AIDS						
Blood or bleeding disorders/anemia						
Thyroid disorders						
Kidney disorders						
Deceased (age)	N/A					

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

Year	Operation/Illness	Hospital or Treatment Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications	Dosage & Frequency	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins & Supplements	Dosage & Frequency	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONDITIONS/SYMPTOMS --- Please mark any condition you have experienced in the past or currently.

Temperature

- past current Cold hands, Cold fingers, Cold feet, Cold toes, Sweaty hands, Sweaty feet, Hot overall, Afternoon flushes, Night sweats, Heat in the hands, feet, and chest, Hot flashes, Perspire easily, Lack of perspiration, Take water to bed, Thirst, Strongly like cold drinks, Strongly like hot drinks

Energy

- past current Low energy, Difficulty keeping eyes open during day, General weakness, Feel worse after exercise, Shortness of breath, Easily catch colds

Liver/Spleen/Heart Function

- past current Dizziness, Insomnia, Nightmares, Itchy skin, Sharp/stabbing fixed pain, Dull moving pain, Changes in moles, lumps

Heart Function

- past current Pacemaker, Chest pain traveling to shoulder, Palpitations, Anxiety, Restlessness, Mental confusion, Frequent dreams, Wake unrefreshed, Sores on the tip of the tongue

Lung Function

- past current Difficulty breathing, Cough, Sneezing, Sinus congestion, Headache, location: _____, Nasal discharge, color: _____, Respiratory allergies, to what? _____, Nose bleeds, Dry nose, Dry mouth, Dry throat, Sore throat, Dry skin, Sniff neck, Stiff shoulders, Overall achy feeling, Alternating chills & fever, Sadness, Melancholy, Loneliness

Spleen Function

- past current Low appetite, Abrupt weight gain, Abrupt weight loss, Abdominal bloating, Abdominal gas, Gurgling in stomach, Fatigue after eating, Easily bruised, Prolapsed organs (diagnosed): _____, Hemorrhoids, Pensive, Over-thinking, Worry

Spleen, Stomach, Large Intestine Function

- past current Loose stools, Diarrhea, Constipated, Incomplete evacuation, Blood in stools, Mucous stools, Undigested food in stools

Dampness

- past current General sensation of heaviness, Mental heaviness, Mental sluggishness, Mental fogginess, Puffy hands, Edema, location: _____, Sweaty feet, Swollen joints, Chest congestion, Nausea, Snoring

Stomach Function

- past current Large appetite, Burning sensation after eating, Heartburn, Acid regurgitation, Ulcer (diagnosed), Belching, Frequent Hiccups, Stomach pain, Bad breath, Mouth (canker) sores, Bleeding, swollen, or painful gums, Vomiting

Eyes (Liver Function)

- past current Itchy, Bloodshot, Hot, Dry, Watery, Gritty, Blurry vision, See floating black spots, Decreased night vision, Near-sighted, Far-sighted

Mental/Emotional

- past current Mood swings, Compulsive behaviors, Difficulty relaxing, Difficulty focusing, Sensitive, Shyness, Suicidal thoughts

Liver/Gall Bladder Function

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Gall stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Bitter taste in mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache at top of head |
| <input type="checkbox"/> | <input type="checkbox"/> | High-pitched ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Lump (sensation) in throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck tension |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck: Limited range-of-motion |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder tension |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder: Limited range-of-motion |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling sensation |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Tight sensation, location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle twitching/tremors |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramping |
| <input type="checkbox"/> | <input type="checkbox"/> | Anger easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Frustration |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Hopeless outlook |
| <input type="checkbox"/> | <input type="checkbox"/> | Lose temper |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequently unable to adapt to stress; cause of stress: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease (s); specify: _____ |

Kidney/Urinary Bladder Function

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily broken bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore knees |
| <input type="checkbox"/> | <input type="checkbox"/> | Weak knees |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sensation in knees |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Low-pitched ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive hair loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent cavities |
| <input type="checkbox"/> | <input type="checkbox"/> | Loose adult teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | Wake frequently to urinate |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | Fear |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily startled |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory problems |

Urination

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Light Yellow |
| <input type="checkbox"/> | <input type="checkbox"/> | Dark yellow |
| <input type="checkbox"/> | <input type="checkbox"/> | Reddish |
| <input type="checkbox"/> | <input type="checkbox"/> | Clear |
| <input type="checkbox"/> | <input type="checkbox"/> | Cloudy |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Scanty |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Strong odor |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgent |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent |
| <input type="checkbox"/> | <input type="checkbox"/> | Incomplete |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinent |
| <input type="checkbox"/> | <input type="checkbox"/> | Bedwetting |
| <input type="checkbox"/> | <input type="checkbox"/> | Wake to urinate |

Male ---- Genital

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Impotence |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature ejaculation |
| <input type="checkbox"/> | <input type="checkbox"/> | Nocturnal emission |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/itching of genitalia |
| <input type="checkbox"/> | <input type="checkbox"/> | Lumps in testicles |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased libido |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased libido |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (describe) _____ |

Female ---Gynecology

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Menopause |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive blood flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal pap smear |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal pain/itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Uterine fibroids |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast lumps, cysts |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased libido |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased libido |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (describe) _____ |

Currently pregnant? Yes No
Trimester: _____

Past pregnancies:
of live births: _____
of miscarriages: _____
of abortions: _____

Other Information:

Patient Signature _____ Date _____