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# Patient Intake Form

Name: ____________________ Date ________

Phone: Home ____________________ Work ____________________

Address ________________ City __________ State ______ Zip code ________

E-mail ____________________

Would you like to receive my email newsletter? (I send out 2-4/year) Yes ☐ No ☐

Age ______ Weight ______ Height ______ Gender ______ Birthdate ________

Occupation ____________________

Emergency phone ____________________ Relationship to you ____________________

Referred by ____________________

If you found me on the internet, which site?

☐ My website ☐ Citysearch ☐ Google+
☐ My blog ☐ Yelp ☐ Other: ____________
☐ Google reviews ☐ Facebook
☐ Acufinder ☐ Twitter

Main complaint you would like addressed ____________________

____________________

When did this problem begin? ____________________

Have you been given a diagnosis for this problem? Yes ☐ No ☐

If so, what? ____________________

Have you ever been treated with acupuncture before? Yes ☐ No ☐

What other treatments have you tried? ____________________

____________________

**Past Medical History**

Significant illnesses (please include date):

☐ High blood pressure
☐ Heart disease
☐ Hepatitis
☐ Cancer
Type: ____________________
☐ Diabetes
☐ Thyroid disease
☐ Rheumatic fever
☐ Sexually transmitted diseases
Type: ____________________
☐ Asthma
☐ Other (please specify)
____________________

Surgeries: ____________________

Significant traumas (auto accidents, falls etc.): ____________________

____________________

Allergies (drugs, chemicals, foods): ____________________

____________________

Do you have a pacemaker? Yes ☐ No ☐

How often do you exercise? ____________________

What type of exercise? ____________________

Medicines and supplements taken within the last two months (please include prescriptions, over the counter medication, vitamins, herbs): ____________________

____________________

____________________

Do you smoke cigarettes? Yes ☐ No ☐ If yes, how many per day? ____________________

How much coffee, tea or cola do you drink per week? ____________________

How much alcohol do you drink per week? ____________________

Please describe any use of drugs for non-medical purposes: ____________________

____________________

## Family medical history

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Cancer
- ☐ Allergies
- ☐ Seizures
- ☐ Stroke
- ☐ Alcoholism
- ☐ Other (please specify)

____________________

____________________

## General Health

**Please check all that apply**

- ☐ Cold hands
- ☐ Poor appetite
- ☐ Cold feet
- ☐ Insomnia
- ☐ Heavy appetite
- ☐ Fatigue
- ☐ Poor circulation
- ☐ Sweats easily
- ☐ Chills
- ☐ Prefer cold drinks
- ☐ Fevers
- ☐ Dream disturbed sleep
- ☐ Night sweats
- ☐ Prefer warm drinks
- ☐ Vertigo or dizziness
- ☐ Bleeds or bruises easily

☐ Peculiar taste in mouth - tastes like? ____________________

☐ Cravings - for? ____________________

Energy level on a scale of 1-10 (1 = no energy) ____________________

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**Eye Health**

☐ Cataracts
☐ Glaucoma
☐ Dry eyes
☐ Night blindness
☐ Glasses/contacts
☐ Eye strain
☐ Eye pain
☐ Itchy eyes
☐ Red eyes
☐ Conjunctivitis
☐ Blurred vision
☐ Spots in eyes
☐ Sensitivity to light
☐ Other: ______________________

**Head, Ears, Nose, Mouth, Throat Health**

☐ TMJ
☐ Migraines
☐ Facial pain
☐ Mouth sores
☐ Concussions
☐ Teeth problems
☐ Grinding teeth
☐ Swollen glands
☐ Gum problems
☐ Dry mouth
☐ Ringing in ears
☐ Poor hearing
☐ Recurrent sore throat
☐ Prone to sinus infections
☐ Earaches
☐ Allergies: ______________________
☐ Headaches (location: ______________________)
☐ Excessive phlegm (color: ______________________)
☐ Other head or neck problems: ______________________

**Skin and hair health**

☐ Rashes
☐ Hives
☐ Acne
☐ Hair loss
☐ Graying of hair
☐ Eczema
☐ Skin ulcerations
☐ Itching
☐ Other skin or hair problem: ______________________

**Respiratory health**

☐ Coughing blood
☐ Asthma
☐ Pneumonia
☐ Tight chest
☐ Shortness of breath
☐ Difficulty breathing when lying down
☐ Bronchitis
☐ Cough
☐ Cough with phlegm
☐ Other lung or respiratory problem: ______________________

**Cardiovascular health**

☐ Phlebitis
☐ Chest pain
☐ Blood clots
☐ Palpitations
☐ Fainting
☐ Tachycardia
☐ Irregular heartbeat
☐ Heart disease
☐ Low blood pressure
☐ High blood pressure
☐ Swelling of hands and feet
☐ Other: ______________________

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**Gastrointestinal health**

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Gas
☐ Acid regurgitation
☐ Bloating
☐ Belching
☐ Bad breath
☐ Black stools
☐ Bloody stools
☐ Cramping
☐ Mucous in stools
☐ Hemorrhoids
☐ Irritable bowel syndrome
☐ Laxative use (Frequency: ____________)
☐ Other:
___________________________________

Frequency of bowel movements per day ________________

**Musculoskeletal health**

☐ Neck pain
☐ Back pain – Location: ______________________________________
☐ Muscle pain – Location: ______________________________________
☐ Joint pain – Location: ______________________________________
☐ Other joint or bone problems: ______________________________________

**Genito-Urinary health**

☐ Pain on urination
☐ Frequent urination
☐ Blood in urine
☐ Kidney stones
☐ Urgency to urinate
☐ Decreased libido
☐ Increased libido
☐ Impotency
☐ Unable to hold urine
☐ Wake up to urinate
☐ Premature ejaculation
☐ Urinary tract infection
☐ Sexually transmitted disease:
____________________________
☐ Other:
____________________________

How often do you urinate in an average day? ______________________________________

**Gynecology**

☐ Pregnant now
☐ Breast lumps
☐ PMS
☐ Painful period
☐ Vaginal odor
☐ Clots
☐ Irregular flow
☐ Vaginal discharge
(Color: ______________)
☐ Irritability during period
☐ Menopause (Age: ____)
☐ Endometriosis
☐ PCOS (polycystic ovarian syndrome)
☐ Irregular cycle
☐ Fibroids

Number of past pregnancies __________________ Births _______________ Miscarriages ________________
Length of cycle ____________________________ Duration of flow ___________________________________
Date of last period ___________________________________________________________________

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Trying to get pregnant? Yes ☐ No ☐

If yes, are you using assisted reproduction? Yes ☐ No ☐

☐ IUI ☐ IVF Number of cycles? __________ Name of fertility specialist ______________________________

Other reproductive: ______________________________________________________________

Other gynecological concerns: ______________________________________________________

**Neuropsychological**

☐ Seizures
☐ Anxiety
☐ Depression
☐ Irritability
☐ Bad temper
☐ Panic attacks
☐ Easily stressed
☐ Suicidal thoughts or attempts?
When: ______________________
______________________________

Other neurological or psychological concerns: ______________________________________________

**Other Complaints**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________