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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 ☐ Rheumatic fever

☐ Heart disease ☐ Sexually transmitted diseases

☐ Hepatitis Type: _____

☐ Cancer ☐ Asthma

Type: _____ ☐ Other (please specify)

☐ Diabetes _____

☐ Thyroid disease

Surgeries: _____

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

_____

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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

_____

_____

_____

_____