



PATIENT INTAKE FORM

Thank you for coming. Please take the time to fill out this questionnaire carefully in order to receive a complete evaluation. All of your information will be confidential. If you have any questions, please ask.

Full Name:	Date:
Home Phone:	Alt. Phone:
Street Address:	City:
State: Zip:	E-mail Address:
Occupation:	S.S. #:
Emergency Contact:	Marital Status (Circle): S M D W # Children:
Family Physician:	Chiropractor:
Health Insurance: <input type="checkbox"/> Y <input type="checkbox"/> N	Name of Company:
Do they cover acupuncture? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Not Sure	Have you ever received acupuncture? <input type="checkbox"/> Y <input type="checkbox"/> N
Date of Birth: / / Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
How did you hear about this clinic?	
<input type="checkbox"/> <i>Walk in</i> <input type="checkbox"/> <i>Yellow Pages</i> <input type="checkbox"/> <i>Periodicals</i> <input type="checkbox"/> <i>Website</i> <input type="checkbox"/> <i>Referred By:</i> <input type="checkbox"/> <i>Other:</i>	
Please initial here to give your permission for us to thank the person who referred you for treatment::	

Main Problem(s): You would like help with _____.

When did this problem begin? What are the precipitating factors?

Have you been given a diagnosis for this problem? If so, what was it?

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?

What kind of treatment have you tried?

What makes this problem worse? What makes this problem better?

Is there anybody in your family with the same/similar problems? Remarks and additional information:

Medical History: (Please include the month/year when diagnosis was established)

Significant illness: Cancer Diabetes Hepatitis Thyroid Disease Seizures

Fibromialgia Arthritis Tuberculosis Hypertension Emotional Imbalance Anemia

Breathing Problems Heart Disease Digestive Disorders HIV/AIDS Positive Venereal Disease

Other (please specify):

Surgeries:

Hospitalization:

Significant trauma (auto accidents, sports injuries, etc):

Allergies: (drugs, chemicals, foods)

Family Medical History (Please specify member)

Cancer Diabetes Hepatitis

Hypertension Heart Disease Stroke Asthma Alcoholism Miscarriage Other (please specify)

Medicines taken within the last two months (including Vitamins, OTC drugs, herbs, etc., and their dosages):

Occupation Do you usually work Indoors Outdoors?

Occupational stress (chemical, physical, psychological, etc)

Personal Height: _____ Current Weight: _____ One year ago: _____

Weight Maximum: _____ @ year _____.

Habits Do you smoke? Y N What? _____ How many per day? _____ Since when? _____

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

Do you exercise regularly? Y N Please describe your exercise program:

How many hours do you sleep in general? _____ What time to you go to bed? _____

Diet How much coffee do you drink? _____ cups/day ; Colas _____ per day ; tea _____ cups/day

What kind of alcoholic beverages do you usually drink? _____ Average # drinks per week? _____

How much water do you drink per day? _____

Are you a vegetarian? Y N Yes, but not so strict Do you eat a lot of spicy food? Y N

Remarks and additional information (e.g. diet)

Please describe your average daily diet (Please be as specific as possible.):

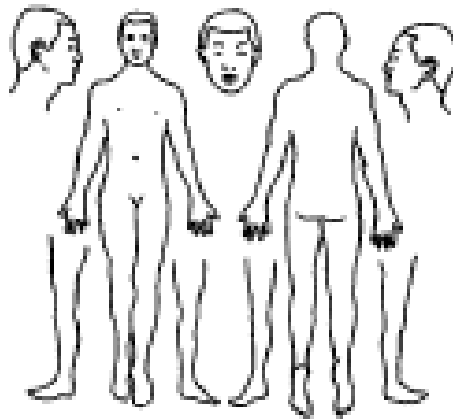
Morning:

Afternoon:

Evening:

Snacks:

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

- | | | | | | |
|--|---|---|---|---|---------------------------------|
| <input type="checkbox"/> General | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings | <input type="checkbox"/> Change in Appetite | |
| <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain | |
| <input type="checkbox"/> Peculiar Tastes | <input type="checkbox"/> Desire Hot Food | <input type="checkbox"/> Desire Cold Food | <input type="checkbox"/> Strong Thirst (cold or hot drinks) | | |
- Sudden Energy Drop (What time of day): _____ Favorite Time of Year: _____ Worst time of Year: _____

Skin & Hair

- Rashes Ulcerations Hives Itching Eczema
 Pimples Dandruff Dry skin Recent Moles Loss of Hair Purpura
 Change in hair or skin textures Dry/brittle nails Acne/rosacea Psoriasis Other?

Musculo-skeletal

- Joint Disorders Muscle Weakness Muscle stiffness Tremors Pain/soreness in muscles
 Difficult Walking Cold Hands/Feet Swelling of hands/feet Sweaty palms/feet Back Pain Spinal curvature
 Neck tightness Hernia Numbness Tingling Paralysis Knee pain
 Hip pain Neck pain Sciatica Arthritis Other

Head, eyes, ears, nose and throat

- Dizziness Concussions Migraines Glasses/lens
 Eye strain Eye pain Color blindness Night blindness Poor vision Cataracts
 Blurry vision Earaches Ringing in ears Poor hearing Sinus problems Nose bleeds
 Sore throat Grinding teeth Spots in front of eyes Facial pain Jaw clicks Sores on lips/tongue
 Gum problems Difficulty swallowing Other

Cardiovascular

- Palpitations Chest pain High blood pressure Low blood pressure Varicose veins Fainting
 Phlebitis Irregular heartbeat Rapid heartbeat Other

Respiratory

- Cough Coughing blood Congestion Wheezing Difficulty in breathing
 Bronchitis Pneumonia Shortness of breath Chest pain Bad breath Repeated sinus infection
 Indigestion Shallow breathing
 Production of phlegm or nasal discharge Clear White Yellow Green Bloody Thick Thin & watery

Gastrointestinal

- Nausea Vomiting Diarrhea Constipation Gas
 Belching Black stools Blood in stools Dry stool Incomplete BM Infrequent bowel movements
 Hemorrhoids Parasites Gallbladder problems Dry mouth/throat Frequently thirsty Lack of thirst
 Rectal pain Abdominal pain/cramps Indigestion Acid reflux Chronic laxative use
 Bad breath

Bowel movements: Frequency _____ **Color:** _____ **Odor** _____ **Texture/Form** _____

Neuro-psychological

- Depression Fearful Worry easily Easily stressed Panic attacks
 Suicidal feelings Loss of balance Concussion Anxiety Stress Bad temper
 Bi-polar Restlessness Lack of coordination Tendency to become obsessive in your work or relationships

Genito-urinary

- Pain on urination Blood in urine Frequent urination Urgency to urinate Unable to hold urine
 Nighttime urination Dribbling Pause of flow Frequent urinary tract infection
 Pain in genitals Itching of genitals Kidney stones Low sexual desire Excessive sexual desire
 Urination issues: Frequent Urgent Profuse Scanty Painful
 Burning Bloody Other

Temperature:

- Aversion to cold Easily chilled Cannot regulate temperature Cold hands
 Aversion to heat Easily overheated Low grade afternoon fever Cold feet Night sweats Hot flashes
 Sweats easily/spontaneously sweats

Female

- Fibroids Frequent vaginal infections Irregular periods Endometriosis Pelvic infection
 Ovarian cysts Clots Vaginal/genital discharge Pain/cramps prior/during periods

Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions _____
 Premature births _____ Caesareans _____ Difficult deliveries _____
 First day of last period _____ Age of first menses _____ Duration of periods _____ days, cycle _____ days
 Do you practice birth control? Yes No If yes, what type and for how long?
 If you are using birth control pills, what are you taking and for how long? _____

Male Prostate problems Discharge Impotence Frequent seminal emission
 Fertility problems Painful/swollen testicles Ejaculation problems Other

Please rate your current pain or discomfort level: (very slight) 1 2 3 4 5 6 7 8 9 10
 Please explain how these conditions affect or impair your daily activities. Examples may include your overall quality of life, work/career, family life, hobbies, self-esteem, etc.

Do you have any history of emotional trauma?
 Do you have any history of surgeries or hospitalizations?
 Do you have any allergies to food, drugs, environment, etc?
 Do you use artificial sweeteners:

FOR YOUR INFORMATION – PLEASE READ CAREFULLY AND SIGN

1. Only sterile, disposable needles are used for your treatment.
2. Occasionally you may get a small hematoma (a little bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern – it will go away after a few days. Gentle pressure applied to the site will stop any small amount of bleeding that is occurring under the skin.
3. Any herbal prescription is intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.
4. After receiving acupuncture treatment, you may feel a little light-headed. If so, please have a seat in our waiting room until this passes.

I have read and understand all of the above information and guarantee this form was completed correctly and to the best of my knowledge.

Signature: _____ Adult patient Parent or guardian Spouse

Are there any other health issues you want to discuss with us?

Signature:

Date:

Identification information update:

Date:

Name:

Occupation:

Marital Status:

Email Address:

Phone:

Address:

Insurance Company:

Other:

Identification information update:

Date:

Name:

Occupation:

Marital Status:

Email Address:

Phone:

Address:

Insurance Company:

Other:

Identification information update:

Date:

Name:

Occupation:

Marital Status:

Email Address:

Phone:

Address:

Insurance Company:

Other:

Note:

