

CONFIDENTIAL ACUPUNCTURE INTAKE

Legal Name (last, first, middle initial): _____ **Date:** ____ / ____ / ____

Birth Date: ____ / ____ / ____ **Age:** ____ **Patient sex:** Male Female

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: (____) _____ **Mobile Phone:** (____) _____ **Email Address:** _____

Employer: _____ **Occupation:** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** (____) _____

Please check appropriate box: Single Married Partnered Divorced Widowed Separated

Referred By: _____ **Physician:** _____ **Permission to consult with your physician?** Yes No

CHIEF COMPLAINT: _____

When / how did this start: _____

Symptoms: _____

List any other Doctors or Therapists you have seen for this condition:

1. _____ 3. _____
2. _____ 4. _____

Recommendations: _____

Treatment(s) received: _____

Are symptoms: Better Worse Unchanged (please circle one)

What makes symptoms worse? _____

What makes symptoms better? _____

Symptoms experienced what percentage of time during a day? 0-25% 26-50% 51-75% 76-100% Other: _____

List previous accidents or injuries (auto, work, falls, etc.) including dates: _____

List any previous surgeries, including dates: _____

List all medications (prescription / non-prescription meds, supplements, herbs), dosage, and when you started/stopped each med:

Habits	Never	Rarely	Occasionally	
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weekly/Daily Amount: _____
Black_tea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weekly/Daily Amount: _____
Soda:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weekly/Daily Amount: _____
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weekly/Daily Amount: _____
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weekly/Daily Amount: _____
Laxatives:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weekly/Daily Amount: _____
Aspirin/NSAIDS:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weekly/Daily Amount: _____
Exercise: (please describe type/amount)	_____			
Stress management tools:	_____			

Health Goals:

By signing below, I indicate the information on both front and back of this page is complete and accurate to the best of my knowledge at this time.

Patient Signature (if minor, parent or guardian must sign) _____ **Date** _____

Current Health Condition (please circle symptoms which have occurred in the past 6 months)

Energy, Immunity, and Metabolism

Fatigue	Catch colds easily	Allergies	Feeling hot/flushed
Energy drops	Slow wound healing	Sweat easily	Fever/chills
General weakness	Chronic infections	Day/night sweats	Recent weight gain/loss

Head, Eyes, Ears, Nose, and Throat

Headaches/migraines	Photosensitivity	Sinus problems/snoring	Sore throat/swollen glands
Dizziness/vertigo	Eye strain/pain/floaters	Nasal congestion	Hoarseness/loss of voice
Vision changes/blurriness	Ear ringing/earaches	Nosebleeds	Teeth grinding

Respiratory and Cardiovascular

Asthma/wheezing	Cough	Palpitations	Varicose/spider veins
Difficulty breathing	Chest tightness/pain	High/low blood pressure	Fainting
Phlegm	Cold hands or feet	High cholesterol	Fluid retention/edema
Pneumonia	Bronchitis	Blood clots	History heart attack/stroke

Gastrointestinal

Low/excessive appetite	Heartburn/acid reflux/ulcers	Dental/gum problems	Diarrhea/loose stools
Difficulty chewing/swallowing	Strong thirst	Abdominal pain/cramps	Constipation
Bad breath	Belching/hiccups	Intestinal gas/bloating	Hemorrhoids/rectal pain
Nausea/vomiting	Gallbladder stones	Food/drug allergies? _____	

Bowel Movements

Frequency: _____	Blood/mucous in stool	Incomplete feeling/pain/urgency	Undigested food
Consistency: well-formed	dry hard pellets loose	soft sticky alternating	
Color: brown	white/chalky green yellow	orange	

Genitourinary

Pain/urgency/burning	Frequent urination	Kidney stones	Change in sex drive
Nighttime urination	Profuse/decreased urination	Urinary retention	Incontinence/dribbling
Blood in urine	Urinary tract infections	Bed wetting	Herpes/STDs/genital sores

Skin, Hair, and Nails

Dry skin/scalp/dandruff	Itching/eczema/psoriasis	Rashes/hives Acne/sores	Easy bruising
Weak/brittle/ridged nails	Scars/moles	Hair loss/thinning	

Neurological and Musculoskeletal

Muscle weakness	Lack of coordination/balance	Muscle spasms/tics/tremors	Numb/tingling/paralysis
Seizures/epilepsy	Poor concentration/memory	Slurred speech	Concussion/TBI/Stroke
Pain: Yes No	Describe location of pain: _____		

Sleep

Difficulty falling/staying asleep	Vivid dreams	Nightmares/night terrors	Sleep talking/walking
Tired upon waking	Restlessness	Avg hours of sleep: _____	Typical bedtime: _____

Emotions

Mood swings	Nervous/anxiety/panic attacks	Frequent worrying/fear	Depression
Seasonal affective disorder	Sadness/tearfulness	Irritability/anger/frustration	Obsessive/compulsive
Mania/elevated mood	Describe your level of happiness _____		

Men Only

Prostate disease	Testicular pain/swelling	Low/excessive sex drive	Premature ejaculation
Hernia	Impotence	Difficulty reaching orgasm	Nocturnal emissions
Poor sperm motility	Irregular morphology	Low sperm count	# of children: _____

Women Only

Hot flashes/flushing	Facial hair growth	Fibroids/cysts/PCOS	Endometriosis
Abnormal vaginal discharge/odor	Nipple discharge	Breast tenderness/lumps	Vaginal dryness
Infertility	Spotting between periods	Difficulty reaching orgasm	Pain during intercourse
First day of last menstrual period: _____		Duration of menstrual cycle (ex: 28 days): _____	
Duration of period (ex: 5 days): _____		Date of last PAP/pelvic exam: _____	
Age of 1st period: _____	Are cycles regular? Yes No	Any abnormal exam results? _____	
PMS symptoms: _____	Birth control? Yes No Type: _____		

Is there any possibility that you are currently pregnant? Yes No Number of pregnancies: _____ Live births: _____

Miscarriages: _____ Abortions: _____ Have you experienced menopause? Yes No If so, when? _____

Please describe menopausal symptoms: _____