

INTAKE FORM

Name (Last)  (First)

Phone Number

Sex  Male  Female Date of Birth  Today's date

Home Address

City  State  Zip Code

EMERGENCY CONTACT

Name  Phone  Relationship

Referred by

Seeking treatment for what health concerns

Onset date

Has any treatment helped this (these) condition(s)? Please list.

What do you find makes it worse?

Have you ever had acupuncture before?  Yes  No

Please list any pharmaceutical drugs or herbs that you are currently taking.

Please list any surgeries, accidents or injuries that you have had (month/year)

Please check all that apply:

GENERAL:

Chills  Fever  Low energy/fatigue  Night sweats  Spontaneous sweating  Aversion to heat  
 Aversion to cold  Recent weight loss  Recent weight gain  Susceptible to colds/flu How many times per year?

EYES/EARS:

- Floaters  Blurry vision  Pain behind eyes  Dry eyes  Inflamed eyes /redness  Tearing  Cataract
- Glaucoma  Infection  Earache  Ringing in ears  Discharge from ear  Other

HEADACHE:

- Headaches Which region (forehead, sides, etc.)   Migraines  Tight band headache
- Sharp headache  Dull headache  Headache with nausea  Other

RESPIRATORY:

- Asthma  Difficulty breathing  Difficulty exhaling  Tightness in chest
- Phlegm in lungs Color if any  Able to bring it up?  Yes  No
- Sensation of something stuck in throat  Coughing up blood  Hoarseness  Loss of voice  Pneumonia
- Current history of pneumonia  Hay fever/allergies  Sinus congestion  Nasal mucus Color if any
- Loss of sense of smell  Other

CARDIOVASCULAR:

- Chest pain/angina  Palpitations  High blood pressure  Low blood pressure  Irregular heartbeat
- Hypochondriac pain (pain under ribs)  Cold hands or feet  Poor circulation  Ankle swelling
- History of heart attack, heart failure  Other

GASTROINTESTINAL:

- Difficulty swallowing  Bloating  Belching  Gas  Abdominal distension  Constipation  Diarrhea
- Burning sensating  Blood in stool  Black stool  Undigested food in stool  Candida/yeast infections
- Irritable bowel syndrom  Gout  Hemorrhoids  No appetite  Insatiable appetite  Nausea
- Acid regurgitation/heartburn  Thirst Is thirst quenched by drinking?  Yes  No  Prefer hot/cold drinks
- Other

URO-GENITAL:

- Urination:  Profuse amount  Urgent/bladder control problem  Scanty amount  Cloudy urine  Frequent urination
- Burning sensation  Urine with blood  Current urinary tract infection  History of urinary tract infections
- Genital pain/swelling  Genital sores  Impotence  Seminal emissions  Low sexual energy  Other

PAIN

- Soreness  Dull  Sharp  Inflamed or swollen Radiates to where?
- Better with cold  Better with heat  Worse in damp weather  Repetitive stress injury
- Result of an accident If so, what type of accident?

NEUROLOGICAL:

- Sensation of numbness  Tingling sensation  Sensation of pins and needles

Location for any of these symptoms:

- Tremors  Drowsiness  Fainting  Vertigo  Paralysis  Stroke  Seizure  Loss of balance

Dizziness Other

SKIN/HAIR:

- Acne  Eczema/psoriasis  Oily skin  Bruise easily  Dark circles/bags under eyes

Sores/lumps Specific areas

- Brittle nails  Dry hair  Hair loss

EMOTIONAL:

- Anxiety  Anger  Depression  Difficulty concentrating  Fear  Nightmares  Irritable  Insomnia

Trouble going to sleep  Interrupted sleep If so, what time do you wake up?

Other

WOMEN:

Age at onset of menses

Length of cycle (ex., every 28 days)

Number of pregnancies

Blood quality:  Dark purple  Bright red  Pale/pink  Clots  Scanty  Heavy

Premenstrual tension  Constipation or diarrhea before or during menses

Feeling of fatigue before or during menses  History of yeast infections/candida  Sores on genitalia

Painful periods  Fibroids  Ovarian cysts  Endometriosis  Abnormal PAP smear  Uterine prolapse

Hysterectomy  C-section  Breast tenderness  Breast lumps Other