

Patient Health Intake
CONFIDENTIAL

Name: _____ Date: _____
Age: _____ Date of Birth: ___/___/___ Sex: ___ M ___ F Marital Status: _____
Home Address: _____ City: _____
State: _____ Zip Code: _____ E-mail: _____
Best way to reach you (circle): Home Phone:(_____) _____ Cell Phone: (_____) _____
Employer: _____ Occupation: _____
If under 18, person responsible for your account? _____
Emergency contact: _____ Phone:(_____) _____ Relation: _____
Medical Insurance Carrier: _____ Policy #: _____
Name of your Medical Doctor: _____ Whom may we thank for referring you? _____
Have you had acupuncture before? Yes / No. With whom? _____
For what condition(s) _____

Please mark any of the following that apply to you:

___ High Blood Pressure ___ Blood Thinning Meds ___ Pacemaker ___ Seizures ___ Pregnancy

Describe the main health concern for which you are seeking treatment: _____

Mild Moderate Severe
Severity of your complaint today: 1 2 3 4 5 6 7 8 9 10 Highest to date? _____

When did you first experience these symptoms? _____

Was there any trauma relating to the onset of your complaint, and if so please describe? _____

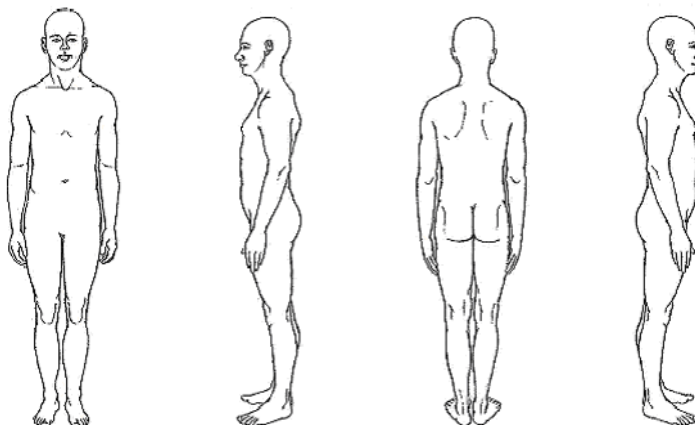
Describe how your complaint affects your daily activities: _____

What have you done to address this complaint: _____

Describe any lab work or imaging you have had done (if any): _____

Please mark the areas of discomfort or pain on the figures using the symbol that best describes the feeling.

- +++ Sharp or stabbing
- ooo Pins and needles
- vvv Dull or aching
- /// Numbness



If you have pain currently, it is:

Sharp Burning Cramping Tingly Dull Aching Numb

Which of the following alleviates it?

Heat Exercise Rest Dry/hot climate
 Cold Activity Pressure Damp/cold climate

Which of the following aggravates it?

Heat Exercise Rest Dry/hot climate
 Cold Activity Pressure Damp/cold climate

Is the pain constant? Yes / No If no, when does the pain occur: _____

Does the pain affect your sleep? Yes / No Does the pain radiate? Yes / No If yes, where? _____

Other comments regarding your pain or main concern today: _____

Women Only:

Pregnant? Yes / No If yes, due date _____ Number of children _____

Are you trying to get pregnant? Yes / No Number of pregnancies: _____

Regular Menstrual cycle? Yes / No Avg. number of days of bleeding _____ Avg. length of cycle _____

Vaginal discharge? Yes / No Bleeding between periods? Yes / No If yes, please describe _____

Painful or symptomatic periods? Yes / No If yes, please describe _____

If applicable, please check the following pre-menstrual symptoms you experience:

<input type="checkbox"/> Dull cramping	<input type="checkbox"/> Breast swelling	<input type="checkbox"/> Hunger/cravings	<input type="checkbox"/> Depression
<input type="checkbox"/> Sharp cramping	<input type="checkbox"/> Bloating	<input type="checkbox"/> Low appetite	<input type="checkbox"/> Nausea
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Migraines	<input type="checkbox"/> Water retention	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Irritability	

If applicable, please check the following menopausal symptoms you experience:

<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Thinning hair
<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Inc. abdomen fat

Other _____

Men Only:

<input type="checkbox"/> Benign prostate hyperplasia (BPH)	<input type="checkbox"/> Erectile dysfunction
<input type="checkbox"/> Urinary difficulty	<input type="checkbox"/> Testicular pain
<input type="checkbox"/> Urinary pain	<input type="checkbox"/> Cold sensation of external genitalia
<input type="checkbox"/> Spermatorrhea	

Are you currently under the care of a medical doctor or other type of health care provider for any conditions? Yes / No

If yes, for what condition? _____

List any medications you are taking (use the other side if necessary):

Medication	Dosage	Prescribed By	Reason	Date started

List any allergies or sensitivities: _____

Dietary Supplements (herbs, vitamins, etc.): _____

Dietary preference: (meat/vegetarian/vegan/other) _____ #meals you eat/day _____

Please list any other conditions or concerns regarding your health: _____

Medical History: Please briefly list major illnesses, traumas, and medical incidents, chronologically (use the back of this sheet if you need more space): _____

Please briefly list your immediate family medical history: _____

The following is a list of some of the many conditions acupuncture effectively treats. Please select any of the following conditions if you would like more information on how we may be able to help.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> IBS | <input type="checkbox"/> Stress | <input type="checkbox"/> Shingles | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Trigeminal |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Sciatica | <input type="checkbox"/> rehabilitation | <input type="checkbox"/> neuralgia |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Interstitial cystitis | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Common cold | <input type="checkbox"/> Low libido | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Flu | <input type="checkbox"/> Vertigo | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Immune weakness | <input type="checkbox"/> Anemia | |

Other comments or questions: _____

Please sign and date

Patient Signature: _____	Date: _____
Acupuncturist Signature: _____	Date: _____