Blossom Acupuncture
Serina Marichiba, L.Ac., Dipl.O.M.
www.BlossomAcupunctureSantaCruz.com
831.325.9338

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:____

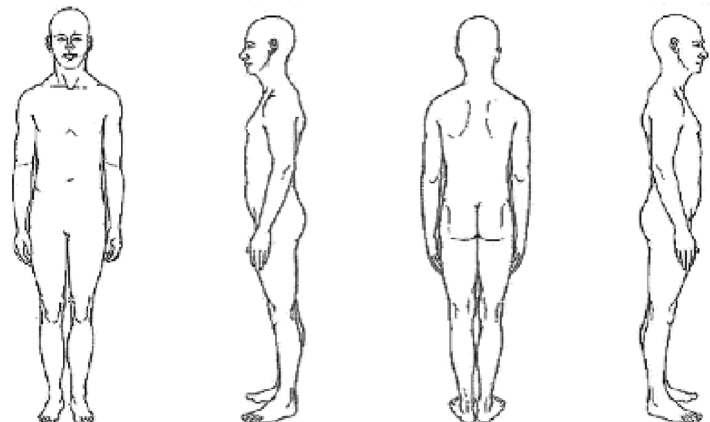
What have you done to address this complaint:____

____

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:

___Dull cramping
___Sharp cramping
___Low back pain
___Breast tenderness
___Breast swelling
___Bloating
___Migraines
___Headaches
___Hunger/cravings
___Low appetite
___Water retention
___Irritability
___Depression
___Nausea
___Vomiting

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

___Hot flashes
___Vaginal dryness
___Sleep disturbance
___Mood swings
___Thinning hair
___Inc. abdomen fat

Other____

Men Only:

___Benign prostate hyperplasia (BPH)
___Urinary difficulty
___Urinary pain
___Spermatorrhea
___Erectile dysfunction
___Testicular pain
___Cold sensation of external genitalia

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.

___IBS
___Acid reflux
___Nausea/vomiting
___Infertility
___Ovarian cysts
___Hot flashes
___Anxiety
___Depression
___Insomnia
___Fatigue

___Stress
___Asthma
___Arthritis
___Tendonitis
___Sciatica
___Carpal tunnel
___Fibromyalgia
___Common cold
___Flu
___Immune weakness

___Shingles
___Bell's Palsy
___Thyroid disorders
___Stroke rehabilitation
___Bladder infection
___Interstitial cystitis
___Low libido
___Vertigo
___Anemia

___Gout
___Migraines
___Headaches
___Trigeminal neuralgia
___Allergies
___Sinus infections
___Addiction

Other comments or questions: ____

____

Please sign and date

Patient Signature:_________________________________ Date:____________________

Acupuncturist Signature:____________________________ Date:_____________________