PATIENT INTAKE

GENERAL INFORMATION

Name: ____________________ Birthdate: ____________

Address: ____________________

Home Phone: ____________ Cellphone: ____________

E-mail Address: ____________________

Marital Status: __________ # of Children: __________ their age(s): __________

Occupation: ____________________ Hours/week ____________

Employer and Location: ____________________

Health Insurance Co.: ____________________

EMERGENCY CONTACT

Name: ____________________ Phone: ____________

Relationship: ____________________

UNDER 18 – Responsible Party Information

Name: ____________________ Relationship to Patient: ____________

HEALTH CARE PROVIDERS – Please Check those that you work with.

- ☐ GP/Primary Care: ____________________
- ☐ OB-GYN: ____________________
- ☐ Specialist: ____________________
- ☐ Chiropractor: ____________________
- ☐ Massage Therapist: ____________________
- ☐ Psychotherapist/Counselor: ____________________
- ☐ Personal Trainer: ____________________
- ☐ Midwife: ____________________
- ☐ Other: ____________________

Have you had Previous Experience with Acupuncture? ☐Yes ☐No

With whom and what were your results?

HEALTH HISTORY

Please describe you major health concerns in order of importance to you: ____________________________________

____

____

____

Check those that apply to your past medical history

☐ Adverse reaction to medical treatment
☐ Alcoholism
☐ Allergies
☐ Arthritis or Rheumatism
☐ Asthma
☐ Attempted Suicide
☐ Birth Trauma
☐ Bleeding Disorder
☐ Blood Disease
☐ Cancer or Tumor
☐ Diabetes
☐ Emphysema
☐ Eating Disorder
☐ Fibromyalgia
☐ Heart Disease
☐ Hepatitis/Liver disease
☐ Herpes
☐ High Blood Pressure
☐ HIV/AIDS
☐ Immune Disorder
☐ Joint Replacement
☐ Kidney Disorder
☐ Low Blood Pressure
☐ Lyme's Disease
☐ Lymph Nodes Removed
☐ Mental Illness
☐ Multiple Sclerosis
☐ Pacemaker
☐ Polio
☐ Rheumatic Arthritis
☐ Rheumatic Fever
☐ Sciatica
☐ Scarlet Fever
☐ Seizures/Epilepsy
☐ Sinus Infection
☐ Skin Disease
☐ Special Diet
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease/STD
☐ Other

List any serious injuries, surgeries, or hospitalizations you have had and the year they occurred:____________________________

____

____

____

Please indicate approximate dates and briefly describe the nature of any emotionally traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc.):

Date____________ Event ______________________________ Date_______ Event _____________________________________

Date____________ Event ______________________________ Date_______ Event _____________________________________

Date____________ Event ______________________________ Date_______ Event _____________________________________

FAMILY HISTORY (list any family physical or mental illness and age of death):

Mother: ______________________________

Father: ______________________________

Grandparents: ______________________________

Siblings: ______________________________

Children: ______________________________

MEDICATIONS, HERBS, and SUPPLEMENTS (list those you are currently taking)

Medication (Rx and OTC)	Reason for Taking	Dose	Date Started

TESTS and IMMUNIZATIONS

Please list your most recent visit:

	Date		Date		Date
Complete Physical		Chest X-ray		Flu Shot	
Mammogram		GI Series		Pnemonia Shot	
Pap Smear		EKG		TB Skin Test	
Stool Blood Test		Sigmoidoscopy		Other	

Please mark symptoms you are currently experiencing or have experienced in the past.

LIVER/GALLBLADER					
Current	Past		Current	Past	
☐	☐	Depression/Stress	☐	☐	Poor Circulation
☐	☐	Headaches/Migraines	☐	☐	Soft/Brittle Nails
☐	☐	Red/Dry/Itchy Eyes	☐	☐	Bitter Taste in Mouth
☐	☐	Visual Problems/Blurred Vision	☐	☐	PMS/Menstrual Problems
☐	☐	Dizziness	☐	☐	Seizures/Tremors
☐	☐	Gallstones	☐	☐	Tendonitis
☐	☐	Feeling of Lump in Throat	☐	☐	Pain Below Ribcage
☐	☐	Clenching Teeth at Night	☐	☐	Do you crave Sour?
☐	☐	Muscle Cramping/Twitching	☐	☐	Tend to be Irritable/Angry?
☐	☐	Neck/Shoulder Pain/Tightness			

HEART/SMALL INTESTINE					
Current	Past		Current	Past	
☐	☐	Heart Palpitations	☐	☐	Vivid Dreams or Nightmares
☐	☐	Rapid or Irregular Heartbeat	☐	☐	Easily Startled
☐	☐	Chest Pain	☐	☐	Dark Urine
☐	☐	High Blood Pressure	☐	☐	Red Complexion
☐	☐	Low Blood Pressure	☐	☐	Do you crave Bitter?
☐	☐	Insomnia/Sleep Problems	☐	☐	Anxiety/ Nervous or Restless

SPLEEN/STOMACH					
Current	Past		Current	Past	
☐	☐	Body Heaviness	☐	☐	Gas/Belching
☐	☐	Hard to get up in the morning	☐	☐	Hemorrhoids
☐	☐	Muscles Often Feel Tired	☐	☐	Organ Prolapse (i.e. uterus)
	_________	Energy Level: 1-10 (low to high)	☐	☐	Chronic Loose Stools
☐	☐	Edema (☐hands ☐feet)	☐	☐	Abdominal Pain
☐	☐	Easily Bruised/Bleeding	☐	☐	Indigestion/Heartburn
☐	☐	Bad Breath	☐	☐	Brain Foggy
☐	☐	Sweet Taste in Mouth	☐	☐	Mouth Ulcers
☐	☐	Lack of Taste	☐	☐	Tendency to Gain Weight
☐	☐	Excess or Low Appetite (circle which)	☐	☐	Do you crave Sweet?
☐	☐	Excess or Lack of Thirst (circle which)	☐	☐	Over-thinking/Worry
☐	☐	Nausea/Vomiting			

Please mark symptoms you are currently experiencing or have experienced in the past.

LUNG/LARGE INTESTINE					
Current	Past		Current	Past	
☐	☐	Bloody Cough	☐	☐	Shortness of Breath
☐	☐	Dry Cough	☐	☐	Allergies/Asthma
☐	☐	Chronic Cough	☐	☐	Low Immunity
☐	☐	Cough with Sputum	☐	☐	Catch Colds Easily
☐	☐	Nasal Discharge	☐	☐	Bronchitis
		☐white ☐yellow ☐green	☐	☐	Black or Bloody Stool
☐	☐	Post Nasal Drip	☐	☐	Constipation
☐	☐	Sinus Infection/Congestion	☐	☐	IBS
☐	☐	Itchy, Red, or Painful Throat	☐	☐	Diarrhea
☐	☐	Dry Mouth/Nose/Throat	☐	☐	Colitis/Spastic Colon
☐	☐	Skin Rashes/Hives	☐	☐	Do you crave Pungent/Spicy?
☐	☐	Snoring	☐	☐	Grief/Sadness

KIDNEY/URINARY BLADDER					
Current	Past		Current	Past	
☐	☐	Urinary Problems (i.e. night-time)	☐	☐	Thyroid Problems
☐	☐	Bladder Infection	☐	☐	Poor Memory
☐	☐	Incontinence	☐	☐	Hair Loss/Grey Hair
☐	☐	Weakness/Pain in Low Back	☐	☐	Hearing Problem/Tinnitus
☐	☐	Osteoporosis	☐	☐	Tooth Cavities
☐	☐	Feel Cold or Hot Easily (circle which)	☐	☐	Hot Flashes / Night Sweats
☐	☐	Cold Hands and or Feet	☐	☐	Impotence or Premature Ejaculation
☐	☐	Low or Excess Sex Drive (circle which)	☐	☐	Do you crave Salt?
☐	☐	Dark Circles Under Eyes	☐	☐	Fear

LIFESTYLE HABITS

Describe your typical daily diet:

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Special Dietary Measures: ____________________

3 Worst Foods You Eat: ____________________

Do You:	YES	NO	
Average 6-8 hours of sleep per night?			What is the quality of your sleep?
Have a supportive relationship?			
Have a history of abuse?			
Enjoy your work?			
Take vacations?			
Spend time outside?			
Exercise Regularly? Frequency?			What activities?
Watch TV?			How many hours weekly?
Read books/magazines?			How many hours weekly?
Play computer games/internet browse?			How many hours weekly?
Have a spiritual/religious practice?			Describe:
Smoke tobacco currently?			How much?
Smoke tobacco in the past?			How much? How long?
Eat out often?			How many meals a week? What type?
Drink coffee?			How many cups per day? With milk and sugar?
Drink tea?			How many cups per day? With milk and sugar?
Drink soft drinks?			How many per day? Diet or Regular?
Use sugar?			How much?
Drink alcohol?			How many drinks per week?
Use recreational drugs?			What? How often?
Have an addiction?			To what? How long?
Been outside of the U.S. in the last 12 months?			Where?

What is the major source of joy in your life? ____

____

____

____

What is the major source of stress in your life? ____

____

____

____

What are the goals for your health? ____

____

____

____

What is you level of commitment to resolving your health issues? (10 = extremely committed)

1 2 3 4 5 6 7 8 9 10