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Acupuncture Intake Form

Name (Last)_____(First)_____
Date of Birth_____ /_____ /_____ **Gender M / F**
Email _____
Address _____City _____State____Zip _____
Phone: Cell (___) _____-_____ Home (___) _____-_____ Work (___) _____-_____
Marital Status: Married/Single **Education** (Highest grade or degree achieved)_____
Option: Height _____ Weight _____ HIV Yes/No HbsAg Yes/No
How did you hear about our clinic?_____
Have you been treated by Acupuncture or Oriental medicine before?
_____

Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

_____ _____
Patient's signature (Parent or Guardian if under 18) **Date**

In an Emergency Notify Name_____ Relationship _____
Phone (Day) (_____) _____-_____

1. Main problem you would like us to help you with:
_____

2. How long ago did this problem begin? _____

3. Have you been given a diagnosis for this problem? If so, what?
_____

4. What kinds of treatment have you tried?
_____

5. Are you currently receiving treatment for your condition? Yes/No
Describe_____

6. Does anything improve your problem?
_____

Past Medical History

Illnesses:
_____
_____
Surgeries_____
_____
_____
Significant Trauma (Auto accidents, falls, etc.)
_____

Do you have, or have you ever had, any **Infectious Diseases**? Yes / No
describe _____

Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

_____
_____
_____

Allergies:

FAMILY MEDICAL HISTORY (GENERAL HEALTH)
Mother's Side
_____
Father's Side
_____
Siblings
_____

If any of the above is deceased, what was the cause?
_____

PERSONAL HISTORY
NEUROPSYCHOLOGICAL
__Seizures __Areas of Numbness __Anxiety
__Concussion __Lack of Coordination __Poor Memory
__Dizziness __Loss of Balance __Easily Angered
__Headaches __Fainting __Depression
__Migraines __Disorientation __Mania
__Easily Susceptible to Stress
Have you ever been treated for emotional problems?
_____
Have you ever considered or attempted suicide?
_____
Any other neurological or psychological problems?
_____
Any nervous habits?
_____
PREGNANCY & GYNECOLOGY
___Age at First Menses ___ Number of Pregnancies __Birth Control?
___Period between Menses ___ Number of Births What type? _____
___Duration of Menses ___ Miscarriages How long?_____
__Unusual Character ___Abortions __Fertility Problems
__Heavy or ___Light __Difficult Births __Vaginal Discharge
__Irregular Periods __Painful Periods __Vaginal Sores
__Breast Lumps __Clots
First Date of Last Menstrual Cycle _____/_____/_____ Date of Last Pap Smear _____/ _____/ _
Do you experience changes in Body and/or Psyche prior to menstruation ?
_____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

__Fevers __Tremors __Change in Appetite
__Chills __Seizures __Peculiar tastes or smells
__Fatigue __Night Sweats __Sudden energy drops?
What time of Day? _____
__Poor Sleep/ Insomnia __Day Sweating __Strong thirst for Hot or Cold drinks?
__Dream Disturbed Sleep __Poor Balance __Headaches
__Depression __Weight Loss __Localized Weakness
__Mania □ Weight Gain ___Bleeding or Bruising
__Emotional Changes __Poor Appetite __Joint Pain

CARDIOVASCULAR

__High blood pressure __Dizziness __Swelling of Hands __Blood Clots
__Irregular heartbeat __Fainting __Difficulty in Breathing __Palpitations
__Low blood pressure __Cold Sweats __Cold Hands/Feet
__Chest pain __Swelling of Feet __Phlebitis

RESPIRATORY

__Cough __Pain w/ Deep Breaths __Difficulty in Breathing
__Asthma __Bronchitis __Shortness of Breath
__Easily Winded w/ Exertion when laying down __Coughing Blood
__Production of phlegm What Color? _____

GASTROINTESTINAL

__Nausea __Abdominal Pain/ Cramps __Digestive Disorders
__Vomiting __Parasites __Constipation
__Indigestion __Belching __Diarrhea
__Ulcers __Bad Breath __Blood in Stools
__Hernia __Hemorrhoids

GENITO-URINARY

__Pain on Urination __Decrease in Urine __Kidney sores
__Urgent Urination __Blood in Urine __Waking up to Urinate
__Frequent Urination __Impotency/ Infertility How often? _____
__Unable to Hold Urine __Genital Sores

MUSCULOSKELETAL

__Muscular Weakness __Arthritis __Recent Sprains
__Muscle Cramps __Spasms
__Injuries or Falls __Muscular Atrophy
__General Aches __Joint Instability

Please circle on the diagram any areas of any type of pain or injury.
Please try to describe the type and quality of the pain
_____
Are there any other internal organ or systemic dysfunctions that we should be aware of?
_____
_____
_____
Are there any other problems you would like to discuss?
_____
_____