ACUPUNCTURE INTAKE FORM

Present Health Concerns (please list in order of importance and significance)

1. CC: _____ Date of Onset: _____
Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation □ Other _____
Are you currently or have you previously been treated for this problem? □ Y □ N
By whom: _____
Type of Treatment: _____

2. CC: _____ Date of Onset: _____
Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation □ Other _____
Are you currently or have you previously been treated for this problem? □ Y □ N
By whom: _____
Type of Treatment:_____

3. CC: _____ Date of Onset: _____
Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation □ Other
_____
Are you currently or have you previously been treated for this problem? □ Y □ N
By whom:_____
Type of Treatment:_____

Please list all current **medications** with dosages (any medication used within the past 2 months)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

*If medication list exceeds lines provided, please bring a list of medications to next visit

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please list any **allergies** you have

Medications: _____

Food: _____

Other (ie pollen, latex etc) _____

Who is your primary care physician? _____ Phone (_____) _____-_____

Health History:

Past Medical History:

Please list any past or present medical diagnoses. Include date diagnoses, who made the diagnosis and if and when the issue has been resolve.

Please list any recent medical tests including blood work, x-rays, CT, MRI, Bone Scans and date of last physical

Surgical History

□ Abdominal/Gastrointestinal	□ Cardiovascular Procedure	□ Joint Procedure	□ Prostate/ Genitourinary
□ Back Surgery	□ Gynecological/Genitourinary	□ Neck Surgery	□ Skin Procedure
□ Other:			

Family History (please indicate which family member)

□ Arthritis	□ Cancer	□ Psychiatric
□ Heart Disease	□ High Blood Pressure	□ Diabetes
□ Thyroid	□ High Cholesterol	□ Stroke
□ Other		

Social History

Personal Habits:

- □ Tobacco packs/day _____
- □ Alcohol drinks/wk _____
- □ Coffee/tea/cola cups/day _____
- □ Recreational drugs times/wk _____

Stress level

□ Mild □ Moderate □ Severe

Reason:_____

_____

Any dietary restrictions?
If yes, describe

_____

Work Activity Level

- □ Sitting % of time _____
- □ Standing % of time _____
- □ Light Labor % of time _____
- □ Heavy Labor % of time _____

Exercise

Do you exercise regularly? □ Y □ N
If yes, describe routine and how often: _____

_____

_____

Review of Systems:

Constitutional ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **Chills**
- ☐ **Fever**
- ☐ **Dizziness**
- ☐ **Night Sweats**
- ☐ **Weight Loss**
- ☐ **Weight Gain**
- ☐ **Daytime Drowsiness**
- ☐ **Fatigue**
- ☐ **Poor Appetite**
- ☐ **Heavy Appetite**
- ☐ **Changes in Taste**
- ☐ **Cravings**
- ☐ **Strong Thirst**
- ☐ **Sweat Easily**
- ☐ **Bleed/Bruise Easily**
- ☐ **Change in Bowel**
- ☐ **Change in Bladder**
- ☐ **Change in Sleep**

Skin and Hair ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of Skin Disorders**
- ☐ **Rash/Hives**
- ☐ **Itching**
- ☐ **Skin Lesions / Ulcers**
- ☐ **Changes in Skin Color**
- ☐ **Dry Skin**
- ☐ **Dandruff**
- ☐ **Eczema/Psoriasis**
- ☐ **Acne**
- ☐ **Fungal Infection**
- ☐ **Changes in finger/toe nails**
- ☐ **Recent moles**
- ☐ **Change in Skin Texture**
- ☐ **Varicosities**
- ☐ **Hair Loss**
- ☐ **Hair Growth**
- ☐ **Change in Hair Texture**
- ☐ **Other**

If Other Please Describe: _____

Eyes Vision ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **Wear Glasses/Contacts**
- ☐ **Blindness**
- ☐ **Change in Vision**
- ☐ **Night Blindness**
- ☐ **Eye Pain/Strain**
- ☐ **Red Eyes**
- ☐ **Dry Eyes**
- ☐ **Floaters**
- ☐ **Spots in Front of Eyes**
- ☐ **Excessive Tearing**
- ☐ **Blurred Vision**
- ☐ **Double Vision**
- ☐ **Glaucoma**
- ☐ **Cataracts**
- ☐ **Other**

If Other Please Describe: _____

Head, Ears, Nose and Throat ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of Head Injury**
- ☐ **Concussions**
- ☐ **Headaches**
- ☐ **Earaches/Infections**
- ☐ **Tinnitus (ringing in ears)**
- ☐ **Ear drainage**
- ☐ **Poor Hearing**
- ☐ **Nosebleeds**
- ☐ **Sinus Problems**
- ☐ **Postnasal Drip**
- ☐ **Excess Phlegm**
- ☐ **Recurrent Sore Throats**
- ☐ **Swollen Glands**
- ☐ **Mouth Sores**
- ☐ **Dry Mouth**
- ☐ **Excess Saliva**
- ☐ **Teeth Problems**
- ☐ **Dentures**
- ☐ **Snoring**
- ☐ **Difficulty Swallowing**
- ☐ **Hoarseness**
- ☐ **TMJ problems**
- ☐ **Teeth Grinding**
- ☐ **Other**

If Other Please Describe: _____

Cardiovascular ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of Heart Disease**
- ☐ **High blood pressure**
- ☐ **Low blood pressure**
- ☐ **Angina (chest pain or discomfort)**
- ☐ **Shortness of Breath with Exercise**
- ☐ **Claudication (leg pain/ache)**
- ☐ **Difficulty Breathing Lying Down**
- ☐ **Heart Murmur**
- ☐ **Irregular Heart Beat**
- ☐ **Palpitations**
- ☐ **Fainting**
- ☐ **Cold Hands/Feet**
- ☐ **Swelling of Hands**
- ☐ **Swelling of Legs/Feet**
- ☐ **Blood Clots**
- ☐ **Phlebitis**
- ☐ **Varicose veins**
- ☐ **Other**

If Other Please Describe: _____

Respiratory ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of Respiratory Disease**
- ☐ **Cough**
- ☐ **Shortness of Breath**
- ☐ **Coughing Blood**
- ☐ **Phlegm Production**
- ☐ **Wheezing**
- ☐ **Asthma**
- ☐ **Bronchitis**
- ☐ **Pneumonia**
- ☐ **Pain with Deep Breathing**
- ☐ **Tightness of Chest**
- ☐ **Other**

If Other Please Describe: _____

Gastrointestinal ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of GI Disorders**
- ☐ **Nausea**
- ☐ **Abdominal Pain**
- ☐ **Jaundice**
- ☐ **Indigestion**
- ☐ **Belching**
- ☐ **Hiccups**
- ☐ **Vomiting**
- ☐ **Vomiting Blood**
- ☐ **Bad Breath**
- ☐ **Diarrhea**
- ☐ **Constipation**
- ☐ **Gas/Bloating**
- ☐ **Abnormal Stool Caliber**
- ☐ **Abnormal Stool Color**
- ☐ **Abnormal Stool Consistency**
- ☐ **Blood in Stool**
- ☐ **Mucus in Stool**
- ☐ **Black - Tarry Stools**
- ☐ **Hemorrhoids**
- ☐ **Rectal Bleeding**
- ☐ **Itchy Anus**
- ☐ **Burning Anus**
- ☐ **Other**

If Other Please Describe: _____

Genitourinary ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History or Renal Disease**
- ☐ **Painful Urination**
- ☐ **Blood in Urine**
- ☐ **Increased Urination**
- ☐ **Decreased Urination**
- ☐ **Urgency to Urinate**
- ☐ **Incontinence**
- ☐ **Bedwetting**
- ☐ **Kidney Stones**
- ☐ **Bladder Stones**
- ☐ **Frequent UTI's**
- ☐ **Chronic Yeast Infection**
- ☐ **Sores on Genitals**
- ☐ **Genital Itching/Burning**
- ☐ **Other**

If Other Please Describe: _____

Male Reproductive ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of Reproductive Disease**
- ☐ **Prostate Problems**
- ☐ **Hesitancy/ Dribbling**
- ☐ **Change in Flow of Urine**
- ☐ **Urine Retention**
- ☐ **Waking to Urinate**
- ☐ **Nocturnal Emission**
- ☐ **Premature Ejaculation**
- ☐ **Erectile Dysfunction**
- ☐ **Impotency**
- ☐ **Change in Libido**
- ☐ **Other**

If Other Please Describe: _____

Female Reproductive ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of Reproductive Disease**
- ☐ **Premenstrual Syndrome**
- ☐ **Menstrual Cramps**
- ☐ **Painful Menses**
- ☐ **Irregular Menstruation**
- ☐ **Hot Flashes**
- ☐ **Vaginal Discharge**
- ☐ **Vaginal Odor**
- ☐ **Vaginal Dryness**
- ☐ **Vaginal Sores**
- ☐ **Breast Lumps/Pain**
- ☐ **Other**

If Other Please Describe: _____

Menstrual History: **Age of First Menses:** _____ **Age of Menopause:** _____

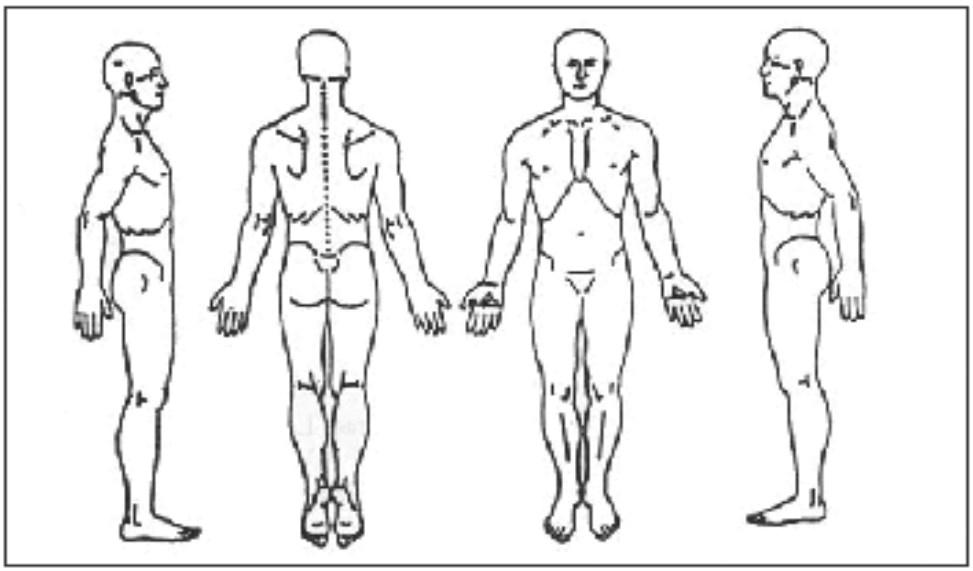
First Day of Last Menses: _____ **Length of Cycle:** _____ **days** **Duration of Period:** _____ **days**

Pregnancy History: **Number of Births** _____ **Number of Pregnancies** _____ **Number of Abortions** _____

Musculoskeletal ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of Muscle Disease**
- ☐ **History of Skeletal Disease**
- ☐ **Scoliosis**
- ☐ **Neck Pain**
- ☐ **Upper Back Pain**
- ☐ **Lower Back Pain**
- ☐ **Shoulder Pain**
- ☐ **Hand/Wrist Pain**
- ☐ **Hip Pain**
- ☐ **Knee Pain**
- ☐ **Foot/Ankle Pain**
- ☐ **Altered Gait (i.e. Limp)**
- ☐ **Loss of Grip Strength**
- ☐ **Muscle Pains**
- ☐ **Muscle Weakness**
- ☐ **Cramps/Spasm**
- ☐ **Numbness**
- ☐ **Tingling**
- ☐ **Joint Pain/Stiffness**
- ☐ **Limited Motion in Joint**
- ☐ **Other**

If Other Please Describe: _____



Please draw location and type of pain on body outline.

Ache ^^^^^^ ^^^	Burning = = = = = = = = = =
Numbness ooooooo oooo	Pins and Needles ……. …….
Stabbing //////// ////	Other xxxxxx xxx

Please indicate level of pain on line

0 No Pain — 10 Worst Possible Pain

Neurological ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **Seizures**
- ☐ **Loss of Consciousness**
- ☐ **Stroke**
- ☐ **Difficulty Speaking**
- ☐ **Loss of Balance**
- ☐ **Unsteadiness of Gait**
- ☐ **Loss of Memory**
- ☐ **Concussion**
- ☐ **Tics**
- ☐ **Tremors**
- ☐ **Lack of Coordination**
- ☐ **Memory Loss**
- ☐ **Sleep Disturbances**
- ☐ **Restless Leg**
- ☐ **Other**

If Other Please Describe: _____

Psychological ☐ **I DENY** having or have had any of the symptoms or problems listed below

- ☐ **History of Emotional/Physical Abuse**
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Irritability**
- ☐ **Easily Stressed**
- ☐ **Behavioral Change**
- ☐ **Alcohol Dependency**
- ☐ **Sudden Mood Changes**
- ☐ **Insomnia**
- ☐ **PTSD**
- ☐ **Other**

If Other Please Describe: _____

Signature _____ **Date:** _____

Thank you. Please return to the front desk.