ACUPUNCTURE INTAKE FORM

Name: _____ Date of Birth: _____ Home Phone _____
Address: _____ Work Phone _____
City: _____ State: _____ Zip: _____ e-mail: _____
Occupation: _____
How did you hear about us? (circle and list a name) patient: _____
MD: _____ ad: _____ friend: _____

MAIN REASON(S) FOR SEEKING TREATMENT:

History:

Duration:

Family history (of same):

Western diagnosis (if any):

Treatments tried:

What makes it worse / better:

Please list any significant past illnesses / hospitalizations / accidents (date of first occurrence, recurrence):

Illnesses: (hepatitis, seizures, thyroid disease, heart or veneral disease, cancer, diabetes, HIV...)

Hospitalizations:

Accidents:

List any current medications / supplements: * SEE BACK PAGE FOR SPACE

Approximately how many times have you taken antibiotics? _____

Are you on Birth Control Pills? _____

Family Medical History: (circle) Arthritis Cancer Diabetes High Blood Pressure
Auto-Immune disease Suicide Venereal Disease Seizures Obesity
Heart Disease Emphysema

Other: _____

Lifestyle:

Occupational Stress: (physical, emotional, chemical) _____
Do you exercise regularly? Yes _____ No_____ Describe _____
Do you eat sugar? Yes____ No____ How much per day _____
Do you smoke? Yes____ No____ How many cigarettes / other per day? _____
How many cups of each do you drink per day?
Water ____ Coffee ____ Tea ____ Alcohol ____ Sugar soda ____
How many hours of sleep do you average per night? _____ Is this enough? Y / N
Diet: (circle) Eating meals regularly / Irregularly / Overeat / Undereat
Vegetables daily / Meat daily / Milk daily / Fruit daily / Protein daily

Please check the following:

HEAD / EYES / EARS / NOSE:

Headaches: ___ Please describe: (duration, frequency, quality of pain, area of head, migraine)

Hair loss: __ Itchy scalp / dandruff: ___ Dry hair: ___ Premature graying: ___
Ear aches: ___ Poor hearing: ___ Ringing: ___ Itchy / Fluid in inner ear: ___ Freq. ear inf.: __
EYES: Decreased vision: ____ Spots/ "floaters": ___ Dry / itchy / "sandy": ___ Eye pain: ____
Red eye ___ Night blindness: ___ Photophobia: ___ Blurry vision: ___ Puffy eyes: ____
Dark circles: ___
Frequent nosebleeds: ___ Chronic post-nasal drip or stuffy nose: ___
Sinus problems / pain: ___ Allergies: ___ If yes, when _____
to what? _____
Teeth or gum problems: ___ Mouth sores: ___ Strange taste in mouth:
(describe) _____
Dry mouth / lips / throat: ___ Excessive salivation: ___ Bad breath: ___ Itchy throat: ___
Streptococci or Staphylococci inf.: _____ Throat constriction: _____ Frequent sore
throat: _____ Grinding teeth / jaw pain: _____ Gums bleeding: ____ TMJ: ___

Other: (please describe) _____

CHEST / HEART / LUNGS:

High Blood Pressure: ___ Low Blood Pressure: ___ Fainting: ___ Dizzy: ___
Irregular heartbeat / palpitations: ___ Chest pain / Pressure: ___ Difficulty inhaling: ___
If Yes to above, please describe (when / how long/ quality/
Triggers): _____
Circulation: (circle) cold / numb / tingling / swelling / dark skin / sweating: (check)
Hands ___ Feet / Legs: ___ or Face flushing: ____ Red face: ____ Raynaud's dis.: ___
Edema: ___
Other chest / heart problems: _____

Cough: ___ If Yes, with Blood: ___ Pain: ___ Phlegm: ___ Worse in a.m. / p.m. / with food:
(circle)
If Phlegm: (circle) White / Yellow / Clear / Thick / Watery / Profuse / Scanty / Difficult
To expectorate / Easy
Pain with Inhalation: ___ Difficult Inhalation: ___ Difficult Exhalation: ___ Shortness of
Breath: ____
Frequent allergies: ___ Frequent Cold / flu: ___ Asthma: ___ Bronchitis: ___ Pneumonia:___
Other Lung problems: _____

GASTROINTESTINAL: (check)

Significant thirst: ___ Prefer to drink: (circle) cold / warm / dislike drinking water
STOMACH; Strong hunger: ___ Poor appetite: ___ Nausea / vomiting: ___ Acid reflux:___
Abdominal pain / cramps: ___ Belching / gas: ___ Bloating: ___ Bad Breath: ___
STOOL: Constipation / dry stools: ___ If yes, describe: Chronic / Sporadic / dark / small "balls" / pain / blood / difficult to pass / other: _____
Diarrhea / loose stools: ___ If yes, describe: Chronic / occasional / with some foods / Foul / blood / pain / "burning" / what time of day? _____
Rectal pain / bleeding: ___ Rectal Prolapse ___ Hemorrhoids: ___ Other _____
Gallstones: ___ Pancreatitis: ___
Difficulty digesting any food? Describe: _____
Any taste / food cravings? _____
Any taste / food intolerances/allergies? _____

Other gastrointestinal problems: (GI tumors, IBS, Colitis, Crohn's) _____

_____

_____

GENITO-URINARY:

Urination: pain ____ incontinence ___ "dribbling" ___ weak stream ___ difficulty _____ blood ___ "burning" ___ urgency ___ frequent urination ___ night urination ___ scanty urine _ strong smelling ___
Color of urine: Dark ____ Medium yellow ____ Clear or Pale ____ Brownish ____ Pinkish ____
Kidney stones: ___ Low back pain: ___ Testicular or vaginal pain: ___ Nocturnal emission: __
Low sex drive: ___ Excessive sex drive: ___ Impotence: ___ Genital Inflammation / sores: ___
Urinary Tract Infection (how many): ____
Other (please describe): _____

_____

AUTOIMMUNE & INFLAMMATORY :

Rheumatism: ___ Arthritis: ___ Systemic Lupus Erythematosus: ___ Connective tissue or ligament diseases: __ Pericarditis: ___ Glomerulonephritis: ___ Plantar Fasciatis: ___

SKIN: (circle)

Dry ___ Oily ___ Itchy ___ Flaky ___ Acne __ Easy bruising ___ Rashes ___ Easily irritated ___ Psoriasis ____ Eczema ___ sun allergy ___ moles ___ difficulty healing _____
Other (please describe): _____

_____

SLEEP: Good ____ __ Fair _____ Poor _____ Nightmares _____
Sleepwalking / talking _____
Difficulty falling asleep _____ Walking _____ if walking: what time _____
Other _____

MUSCULO-SKELETAL:

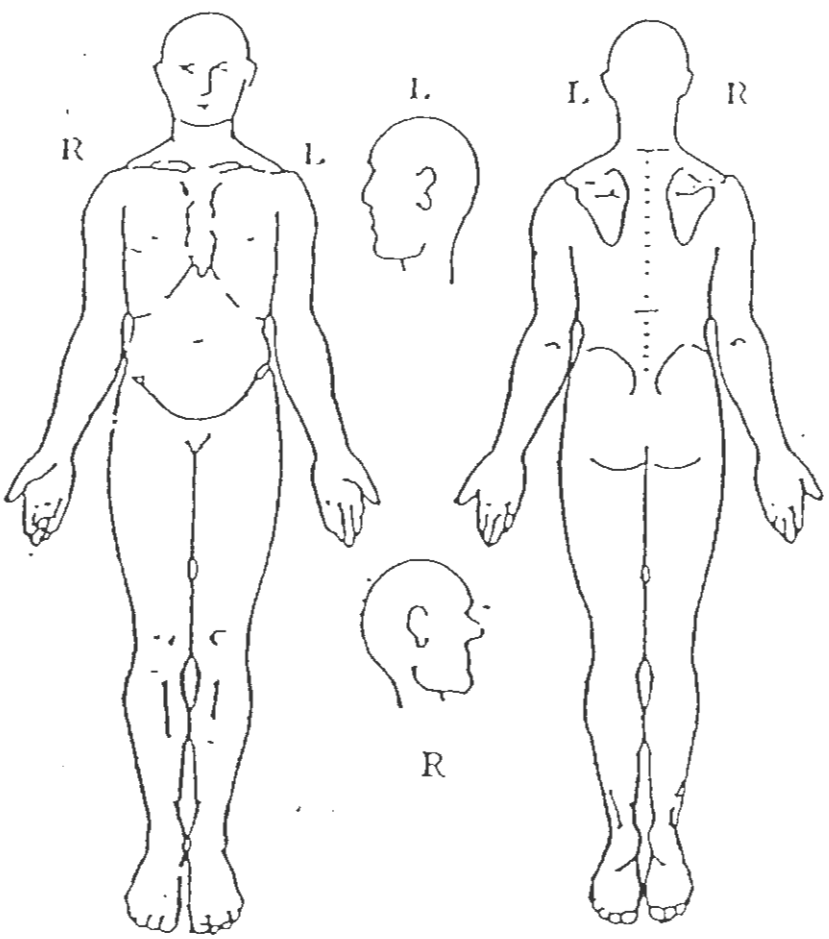
Back Pain: Upper_____ Midback _____ Low back _____ Chronic_____ Recent / Acute_____
Quality of Pain: Stiffness / Aching_____ Dull ____ Mild_____ Constant _____ Comes + Goes_____ Sharp_____ "Stabbing"_____ "Burning" _____ Severe_____ Moves Around_____
Worse: In a.m.____ When tired____ At Night____With Heat____With Cold____With massage____
When you move / exercise_____ Damp days _____In the Winter____ In the Summer_____
Better: With exercise____With Heat____With Ice_____ Massage_____With Rest____
When lying down ____ Has it gotten worse / better over time?_____
When did you first have back pain?_____
_____

Knee Pain: Chronic____ Acute_____Worse on Damp Days____Worse When Tired____Stiff ____ Sharp_____

Hand /Wrist Pain:____ **Neck Pain**:____ **Foot /Ankle** Pain:_____ **Shoulder** Pain:____
Hip Pain:____

General Muscle tension:____ General Muscle Pain / Tenderness / Weakness (circle) General Joint Pain:____Scoliosis:____ Uneven leg lengths:____ Osteoporosis:_____
Leg Cramps:___ Sciatica:____ Muscle Twitching / Spasms:____ Areas of Numbness:_____
Fibromyalgia:____
Other :_____
_____

PLEASE MARK AREAS OF PAIN/ PROBLEM:



GYNECOLOGICAL:

MENSTRUATION: Age of first flow: _____ Duration of flow: _____ Interval between Periods: _____
During Period: Pain / Cramping: ____ Loose Stools: ____ Low Back Pain: ____ Nausea: ____
Feeling Hot: ____ Increased appetite: ____ Chocolate craving: ___ Fatigue: ____ Muscle Pain: _____ Bloating: ____ Poor Digestion: _____
Blood Flow: Bright Red ____ Brown ____ Dark Red ____ Watery ____ Purplish ____
Heavy ____ Medium ____ Light ____ Spotting ____ Clots ____
Irregular menstruation: Delayed ____ Begins Early ____ Sporadic or Unpredictable ____
Spotting between periods ____
PMS: Breast tenderness ____ Increased irritability ____ "Weepy" ____ Cramping ____
Headache ___ Body aches ___ Change in sleep patterns ___ Constipation ___ Loose stool ___
Temperature Fluctuations ____ Food cravings ____ Change in Energy Level ____
Bloating / edema ____

Any other changes in body / psyche with menstruation? _____
_____

Vaginal discharge: Profuse ____ Thick ___ Watery ___ Foul smell ___ Itching ___ Chronic ___
Occasional ____ Currently ____ Yellow ____ White ____

Have you ever taken Birth Control Pills:____
When and for how long: _____
Do you currently have an IUD in Place: _____
Are you currently pregnant: ____ # of pregnancies: ___ # of births: ____ # of miscarriages: ____

Are you currently trying to become pregnant? _____

MENOPAUSE: Age at onset of menopause: ____

Any current symptoms? Hot flashes ____ Dizziness ____ Night Sweats ____ Irritability ____
Poor Sleep ____
Temperature Fluctuations ____ Dry Skin or Hair ____ Vaginal dryness ____ Low Libido ___
Poor Memory ____ Low Energy ____
Other _____

NEUROPSYCHOLOGICAL:

Seizures: ___ Areas of Numbness / Tingling: ___ Uncontrolled twitching / muscle Spasms: ___ Loss of Balance: ___ Lack of Coordination: ___ Neuropathy: ____
Multiple Sclerosis: ____ Bell's Palsy: ____ Paralysis: ____
Other neurological problem: _____

Anxiety: ____ Panic Attacks:____ Depression: ____ Irritability: ____ High Stress: ____
Emotional Turmoil: ____ Overly excited or manic ____

Medications _____

OTHER:

Sweating: Day ____ Night ____ Fevers: ____ Chills:____
Do not sweat easily ____ Sweat has strong odor _____ Sweat stains clothes _____

Energy: Poor ____ Fair ____ High ____ Easily become tired ____ Need naps ____
Sporadic ____ Better with exercise ____ Worse with exercise ____ Groggy in the morning ____
Tired after eating ____ Very alert at night ____
Time of day your energy dips: _____
Season you feel best? _____ Season you feel worst?_____
Please rate your general Energy from 1-10 (10 = best, 1 = worst) _____

Temperature: Feel Cold ____ Feel Hot ____ Temperature Fluctuates ____
Dislike Cold: ____ Dislike Heat: ____
Which temperature fluid do you prefer to drink? Hot ____ Cold ____ Room Temp. ____
Any area of your body feel more:
HOT? _____
Any area of your body feel more:
COLD? _____

MEDICATIONS:

Please list any medications / supplements you are currently taking or have taken in the last 12 months (include dosages):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____