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Confidential Patient Intake Form

On all questions, please use the back of the page for more space.

Today's Date: ______________

Patient Name: ____ Date of Birth: _____________
Given Middle Family

Address: ____
Number Street City State Zip

Telephone Home: ____________________ Cell: ____________________ Work: ____________________

Email: ____ Where may we contact you? ________________

Gender: M/F/other   Single / Married / Separated / Divorced / Lives with: _______________Children? _____

Emergency Contact: ____
Name Phone Relationship

Primary Care Physician: ____
Name Address

Doctor's Phone: ____________________________ May we confer with your Doctor? _Y N_ Initials: _______

Who can we thank for referring you? ____
Name Phone/Address

Have you had acupuncture before? _Y N_ When? _____________ Where? _________________________

What are you here to work on? ____

What makes it better or worse? ____

Have you seen an MD for this? ______________ When? _______________________________________

Were you given a Diagnosis? ____

Please describe any major illnesses or surgeries and when they occurred:____________________________

____

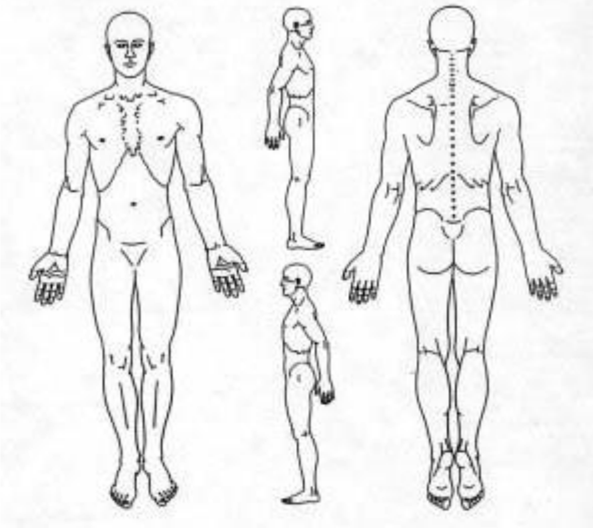
Please list all known Allergies (use the back if you need more space) :___________________________________

____

Please list all medications and supplements are you taking, use the back if you need more space:

Medication/Supplement Name	Reason Taking / Diagnosis	How Long	Dose & Frequency	Last Dose

Please mark the diagram where you have pain



Describe the pain:__________________________

____

When did it start and how?___________________

____

Intensity 1(twinge)-10(unbearable): ___________

Does it travel/refer?________________________

What makes it worse?______________________

What makes it Better?______________________

Do you have any particular food cravings? ____

Do you use tobacco? _______ How? ___________________ How Much? ___________________________
Do you use alcohol? ______ How Much? _________________ How Often? __________________________
Do you use caffeine? ______ How Much? _________________ How Often? __________________________
Do you use other recreational drugs? ________ What? ____
How Much? _________________________________ How Often? _____________________________

Do you **exercise**? _____ How often? ______________ What activities? ______________________________

Sleep: Do you sleep well? ______________ Do you sleep through the night? _________________________

If you wake, what wakes you? _________________ Do you go back to sleep easily?____________________

What are your dreams like?________________________ How is your energy level?____________________

Work:
Occupation: ____

Do you spend your day – Sitting / At a computer / Standing / Walking / Lifting & Carrying / Other___________

When you're on the telephone – what do you use most of the time? Headset / Speaker Phone / Handset

Women:
Are you pregnant? ___________________ When was your most recent period? _______________________
Are your periods regular? ____________ How many days between first day of periods? _________________
How old were when you had your first period? ___________________ Final Period? ___________________
Do you have PMS? _____________ Moodiness/Emotional? _____ Bloating? _______
Sleep changes? _______ Unusual dreams? _______ Back/Belly Aches? _______ Breast Swelling? _______
During your period: Cramps? _____ Clots? _____ Heavy flow? _____ Scanty flow? _____ # of days: ______
Are you sexually active? ____________ What form of birth control do you use? ________________________
Have you ever been pregnant? ______ Number of: Live births: _____ Miscarriages: _____ Abortions: ______
How old are your children? _______________________ Last Birth/Miscarriage/Abortion: ________________
Are you trying to get pregnant? ________ For how Long? ____________ Interventions: _______________
Date of last gynecological exam: ________________ Breast Imaging: ____________ type: _____________

Men:
Last Prostate exam: ______________________ Enlarged Prostate? __________ Prostate cancer? _______
Urinary problems: Dribbling urine? __________ Slow start of stream? __________ Burning? ____________
Erectile difficulty? ___________ Testicular pain/swelling? ____________ Testicular Cancer? _____________

MEDICAL HISTORY – *This is a big list; read through it and check only the items that apply to you. Please leave everything else blank.*

Please write any details on the back of the page.

___ADD/ADHD
___Anxiety/ Nervousness
___Autism
___Bi-Polar disorder
___Dementia
___Depression
___Dizziness/Vertigo
___Emotional problems
___Insomnia
___Panic attacks
___Schizophrenia/ Schizoaffective disorder
___Sleep disturbances
___Tooth grinding/TMJ

___Epilepsy/Seizures
___Migraine
___Neuritis
___Paralysis
___Stroke

___Dry eyes/Excess tearing
___Earaches
___Eye/Visual problems
___Glaucoma
___Ringing in the ears

___Allergies/Hay fever
___Asthma
___Bronchitis
___Cough
___Eczema
___Emphysema
___Hives
___Pleurisy
___Pneumonia
___Rashes
___Shortness of breath
___Sinus congestion
___Tuberculosis

___Cirrhosis
___Gall stones
___Hepatitis A/B/C
___Liver problems

___Blood in urine
___Dribbling urination
___Frequent urination
___Incontinence
___Kidney disease
___Kidney stones
___Painful urination
___Urinary Tract Infections

___Anemia
___Aneurism
___Angina pectoris
___Bruise easily
___Chest pain
___Heart disease
___Hemophilia
___High/Low blood pressure
___Nose bleeds
___Pacemaker
___Palpitations
___Varicose veins

___Arm pain
___Arthritis
___Back pain upper/mid/lower
___Bursitis
___Disc problems
___Fibromyalgia
___Headaches
___Joint pain
___Leg pain
___Muscle spasms or cramps
___Neck pain
___Osteoporosis/Bone loss
___Pinched nerves
___Scoliosis
___Shoulder pain
___Hip pain
___Knee pain

___Lupus
___MS or other degenerative disease
___Rheumatoid arthritis
___Organ transplant
___Other autoimmune disease

___Breast/Nipple discharge
___Breast pain
___Hot flashes
___Hysterectomy
___Impotence
___Menopause symptoms
___Menstrual problems
___Night sweats
___Ovarian cysts
___PMS
___Painful intercourse
___Prostate problems
___Testicular pain/swelling
___Vaginal dryness
___Vasectomy/Tubal ligation

___Blood in stools
___Constipation
___Crohns disease
___Diarrhea
___Excess appetite
___Frequent hunger
___Gas/Belching
___Heartburn/Reflux
___Hemorrhoids
___Hernia
___Irritable Bowel Syndrome
___Loss of appetite
___Nausea/Vomiting
___Stomach ulcers
___Ulcerative colitis

___Cancer ________________
___Candida
___Chronic fatigue syndrome
___Diabetes Type 1 or 2
___Edema
___Fatigue
___Get sick easily
___HIV/AIDS
___Hypoglycemia
___Hyper/Hypo thyroid
___Lupus
___Obesity
___Poor/Slow wound healing
___Unexplained weight loss

This is as complete a health history as I can give:

Signed: ____ **Date:**____________