gentle acupuncture

CONFIDENTIAL CLINIC INTAKE FORM

DATE: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Preferred Pronoun: _____ Age: _____

Home Address: _____

_____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Occupation: _____

HEALTH HISTORY

I. WHAT IS YOUR EXPERIENCE WITH ACUPUNCTURE?

- Have you received acupuncture treatment before? YES NO
- If yes, for what conditions and what was the outcome?

II. WHAT IS IT THAT YOU WANT TREATED WITH ACUPUNCTURE?

A. Please describe your primary problem or health concern in your own words? How long have you had this problem, and was the onset sudden or gradual? Was there any significant event that led to it?

B. Please describe other problems or health concerns in your own words? How long have you had this problem(s), and was the onset sudden or gradual? Was there any significant event that led to it?

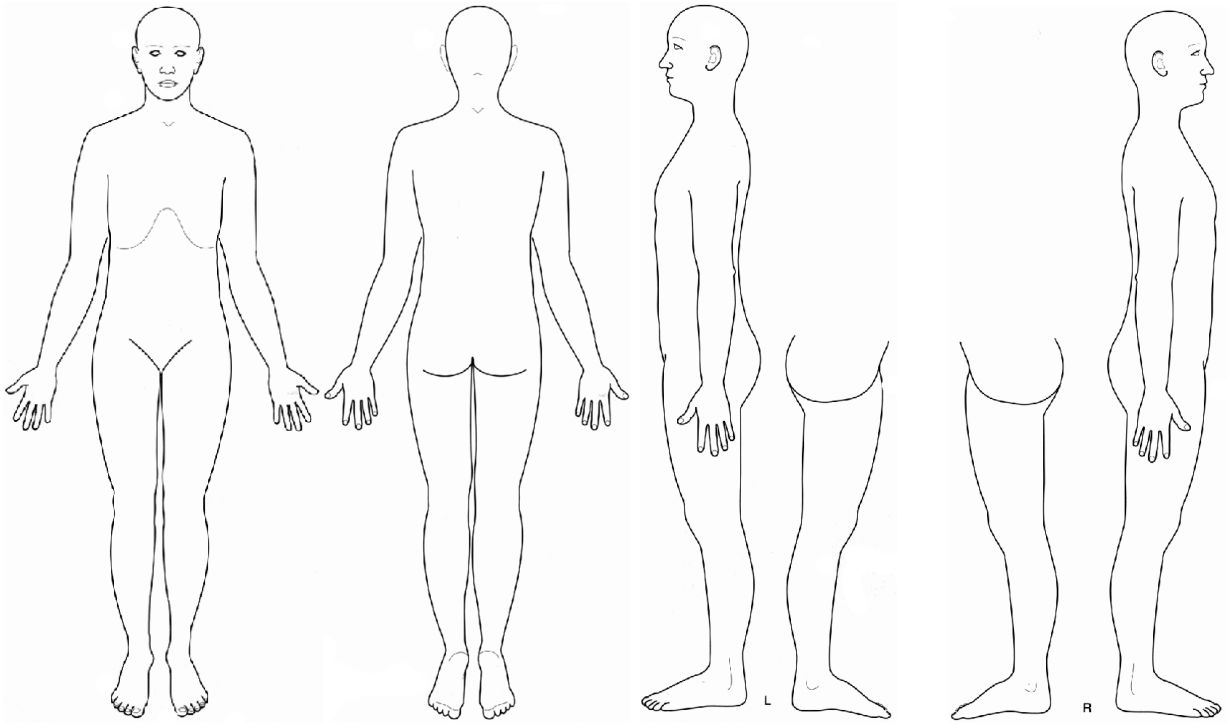
C. Please describe your goals, hopes and expectation for your acupuncture treatment:

D. Have you had a medical evaluation for your problem(s)? If yes, when and what diagnosis did you receive?

E. Other Care: What other therapies are you doing/ have you done to manage for your condition, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

III. WHERE IS YOUR PROBLEM?

Using the diagram, please shade in the areas where you feel symptoms associated with your complaints.



MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are CURRENTLY taking:

Medications, supplements, or herbs:	For what problem or concern:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____

LIST ANY ALLERGIES (to medications, supplements, herbs): _____

_____

IV. PERSONAL MEDICAL HISTORY

II. **BIRTH:** Describe anything significant/traumatic about your birth:

III. **VACCINATION HISTORY:** Any unusual reaction? Any unusual vaccination?

IIII. **CHILDHOOD ILLNESSES (0-12 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

IIV. **ADOLESCENCE ILLNESSES (13-17 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

IV. **ADULTHOOD ILLNESSES (18 – 35 YEARS):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

IVI. **ADULTHOOD ILLNESSES (36 & up):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

V. FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER _____

FATHER _____

SIBLINGS _____

MATERNAL GRANDPARENTS _____

PATERNAL GRANDPARENTS _____

VI. SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY

MUSCULOSKELETAL

- ☐ Joint clicking
- ☐ Limitation of movement
- ☐ Pain or Stiffness
- ☐ Spasms or cramps
- ☐ Swelling
- ☐ Weakness

(WHERE?):

_____

EYES, EARS, NOSE & THROAT

- ☐ Loss of vision, eye pain, tearing
- ☐ Ear pain, loss of hearing, Ringing
- ☐ Problems with balance (vertigo)
- ☐ Olfaction (sense of smell) impaired
- ☐ Nose stuffiness, nosebleeds, sinus pain
- ☐ OTHER (Please list)

_____

_____

RESPIRATORY

- ☐ Chest pain, tightness
- ☐ Coughing up blood (hemoptysis)
- ☐ Shortness of breath (dypsnea)
- ☐ Sore throat
- ☐ Sputum production
- ☐ Wheezing
- ☐ OTHER (Please list)

_____

_____

CARDIOVASCULAR

- ☐ Chest pain &/or pressure
- ☐ Edema
- ☐ Fainting (syncope)
- ☐ Fatigue
- ☐ Palpitations
- ☐ Skin ulceration
- ☐ Swelling of the ankles &/or legs
- ☐ OTHER (Please list)

_____

_____

DIGESTIVE

- ☐ Abdominal distention/bloating
- ☐ Abdominal mass
- ☐ Abdominal pain
- ☐ Acid regurgitation &/or Heartburn
- ☐ Alternating constipation/diarrhea
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Eating disorder
- ☐ Indigestion

DIGESTIVE

- ☐ Jaundice (yellow tint to skin &/or eyes)
- ☐ Nausea
- ☐ Vomiting
- ☐ OTHER (Please list))

_____

UROGENITAL

- ☐ Difficulty with urine flow
- ☐ Incontinence
- ☐ Painful urination, pelvic pain
- ☐ Rashes
- ☐ Red urine
- ☐ Urinary tract infection (UTI)
- ☐ OTHER (Please list)

_____

_____

NEUROLOGICAL

- ☐ Changes in consciousness
- ☐ Confusion
- ☐ Difficulty concentrating
- ☐ Dizziness
- ☐ Dysphasia (impaired ability to speak)
- ☐ Gait disturbance, balance issues
- ☐ Headache
- ☐ Numbness and/or tingling
- ☐ Loss of consciousness
- ☐ Paralysis
- ☐ Post shingles pain
- ☐ Problems coordinating movements
- ☐ Severe forgetfulness
- ☐ Tremor
- ☐ Visual disturbance
- ☐ Weakness
- ☐ OTHER (Please list)

_____

_____

INTEGUMENTARY (SKIN)

- ☐ Changes in hair
- ☐ Changes in nails
- ☐ Changes in skin color
- ☐ Itching
- ☐ Never sweat
- ☐ Rash and/or skin lesion
- ☐ Unusual sweating
- ☐ Wounds that will NOT heal
- ☐ OTHER (Please list)

_____

_____

PSYCHOLOGICAL

- ☐ Feelings of grief
- ☐ Feeling of sadness
- ☐ Feeling fearful/anxious/nervous
- ☐ Difficulty managing anger

☐ Feeling manic
☐ Feeling worried or overly pensive
☐ Feelings of panic
☐ Feeling overwhelmed
☐ Extreme mood swings
☐ Extreme lack of emotion
☐ OTHER (Please list)

_____

_____

SLEEP

☐ Difficulty falling asleep
☐ Dream disturbed sleep
☐ Wake up & cannot fall back asleep
☐ OTHER (Please list)

_____

_____

MISCELLANEOUS

☐ A C F Extremely low energy/fatigue
☐ A C F OTHER (Please list)

_____

_____

FOR MEN ONLY

☐ Unusual discharge
☐ Fertility concerns
☐ Prostate problems
☐ Sexual dysfunction
☐ OTHER (Please list)

_____

_____

FOR WOMEN ONLY

☐ Abnormal vaginal bleeding
☐ Changes in hair distribution
☐ Fertility concerns
☐ Irregular menstruation
☐ Menopausal symptoms
☐ No menses
☐ Pain with menses
☐ Pain during or after sexual relations
☐ Pelvic pain
☐ Premenstrual symptoms
☐ Sexual dysfunction
☐ Unusual discharge
☐ OTHER (Please list)

_____

Are you pregnant OR trying to become pregnant?
YES NO

Have you ever been pregnant? YES NO If yes, how many pregnancies: __

Births ____
Miscarriages ____
Abortions ____

Have you had fertility treatment? YES NO

If yes, when? _____

Where? _____

By whom? _____

What types? _____

_____

_____

Have you taken medication to help ovulate?
YES NO
If yes, what? _____
When? _____
How long? _____

Have your fallopian tubes been medically evaluated?
YES NO
If yes, what were the results?

_____

Have you had any tubal operations?
YES NO

Have you had any hormone lab tests performed?
YES NO

If yes, what were the results?

_____

VII. MEDICAL DISEASES/CONDITIONS

What medical Diseases/Conditions have you been diagnosed?

Heart	Skin	Upper extremities
Lung	Face & Head	Lower extremities
Digestive system	Neck and Thyroid	Bones and Joints
Urinary system		

VIII. LIFESTYLE INFORMATION

A. Stress, Energy Level & Sleep

1. Do you think that stress, including recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:

2. Do you have any problems with your energy level? If yes, please briefly describe:

3. Do you have any problems with sleep? If yes, please briefly describe:

4. Do you have any problems with your sexual drive? If yes, please briefly describe:

B. Smoking, Alcohol & Drugs

1. Do you smoke tobacco? YES NO If yes, do you believe that this is a problem for you?

2. Do you drink alcohol? YES NO If yes, do you believe that this is a problem for you?

3. Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO Do you believe that this is a problem for you?

C. Diet and Nutrition

1. If applicable, briefly describe any problems you think you have with your eating habits and appetite. Do you believe that your diet has any impact on your complaints? YES NO

2. Are you concerned about your weight and/or appetite (under or overweight, too much or too little appetite)? YES NO