Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex ☐ F ☐ M	Date
Date of birth	Age	Occupation	S. S #
E-mail address	Home phone #	Work phone #	
Address: Street		City State	Zip
In Emergency notify		Marital status ☐S ☐M ☐D ☐W	# of children
Family Physician		Chiropractor	
Do you have a health insurance? ☐ Yes ☐ No		Name of insurance company	
Does your insurance cover acupuncture? ☐ Yes ☐ No ☐ ?		Have you ever been treated by acupuncture before?	
How did you know this clinic ? ☐ *Friends/Relatives* _____ ☐ *Periodicals* ☐ *Direct mails;* ☐ *Location or walk by;* ☐ *Website* ☐ *Referred by* _____ ☐ *Yellow Pages;* ☐ *Other (please specify)*			

Main problem(s) : You would like us to help you with _____.

When did this problem begin?

What are the precipitating factors?

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

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?

What kind of treatment have you tried?

What makes this problem worse?

What makes this problem better?

Is there anybody in your family with the same/similar problems?

Remarks and additional information:

Past medical history (Please include the month/year when the diagnosis was established)

Significant Illness:	Cancer	Diabetes	Hepatitis	Thyroid Disease	Seizures
Fibromialgia	Arthritis	Tuberculosis	Hypertension	Emotional Imbalance	Anemia
Breathing Problems	Heart Disease	Digestive Disorders	HIV/AIDS Positive	Veneral Disease	
Other (pleased specify)					

Surgeries:

Hospitalization:

Significant Trauma (auto accidents, sports injuries, etc) :

Allergies: (drugs, chemicals, foods)

Family Medical History (Please specify family member)			Cancer	Diabetes	Hepatitis	
Hypertension	Heart Disease	Stroke	Asthma	Alcoholism	Miscarriage	Other (pleased specify)

Medicines taken within the last two months (including Vitamins, OTC drugs, herbs, etc., and their dosages)

Occupation Do you usually work ☐ indoors ☐ outdoors ?

Occupational stress (chemical, physical, psychological, etc)

Personal Height_____ Weight now_____ One year ago _____

Weight maximum _____@Year _____

Habits Do you smoke ? ☐ Yes ☐ No What? _____ How many per day?_____ Since when? _____

Please describe any use of drugs for non-medical purposes:

Do you exercise regularly ☐ Yes ☐ No Please describe your exercise program:

How many hours do you sleep in general? When do you usually go to bed?

Diet How much coffee do you drink ? _____cups/day ; Colas _____number/day; Tea _____cups/day.

What kind of alcoholic beverages do you usually drink? _____, average number of drinks/week ? _____

How much water do you drink per day? _____

Are you a vegetarian? ☐ Yes ☐ No ☐ Yes, but not so strict Do you eat a lot of spicy food ? ☐ Yes ☐ No

Remarks and additional information (e.g. diet)

Please describe your average daily diet (Please be as specific as possible):

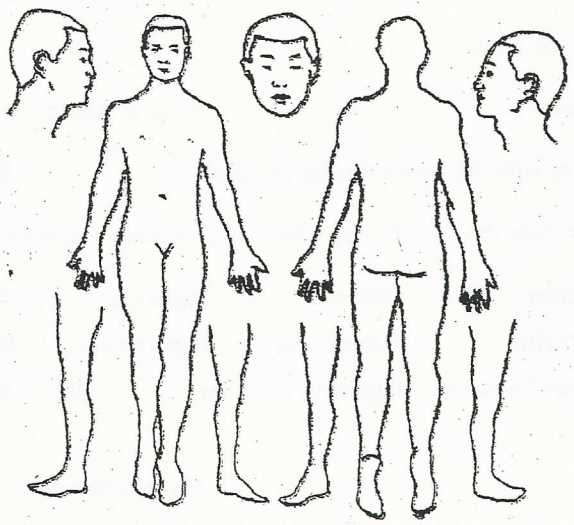
Morning

Afternoon

Evening

Snacks

Indicate painful or distressed areas:



Please check if you have or have had (in the last 3 months) any of the following diseases or conditions.

GENERAL	☐ Poor appetite	☐ Poor Sleeping	☐ Fatigue	☐ Fevers	☐ Chills
☐ Night sweats	☐ Sweat easily	☐ Tremors	☐ Cravings	☐ Change in appetite	
☐ Poor balance	☐ Bleed or bruise easily	☐ Localized weakness	☐ Weight loss	☐ Weight gain	
☐ Peculiar tastes	☐ Desire hot food	☐ Desire cold food	☐ Strong thirst (cold or hot drinks)		

☐ Sudden energy drop (What time of a day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema
☐ Pimples ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair ☐ Purpura
☐ Change in hair or skin textures ☐ Other?

Musculoskeletal ☐ Joint disorders ☐ Weakness muscles ☐ Pain/soreness in the muscles ☐ Tremors
☐ Difficult walking ☐ Cold hands/feet ☐ Swelling of hands/feet ☐ Back pain ☐ Spinal curvature ☐ Hernia
☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain
☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Sprain of joint ☐ Other

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Head, eyes, ears, nose, and throat ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens
☐ Eye strain ☐ Eye pain ☐ Color Blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts
☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes
☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Teeth problems ☐ Facial pain
☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other

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Cardiovascular ☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting
☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other

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Respiratory ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty in breathing
☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm – What color? _____

Gastrointestinal ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Rectal pain
☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Gallbladder problems ☐ Parasites ☐ Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological ☐ Loss of balance ☐ Lack of coordination ☐ Concussion
☐ Depression ☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar

Genito-urinary ☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgent to urinate
☐ Kidney stones ☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection
☐ Pain in genital ☐ Itching of genital ☐ Other

Female ☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal/genital discharge
☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods
☐ Breast tenderness ☐ Breast Lumps ☐ Fertility Problems ☐ Hot flashes ☐ Moodiness related to periods
_____ number of pregnancies _____ number of births _____ Miscarriages _____ Abortions
_____ Premature births _____ Cesareans _____ Difficult delivery
First date of last period _____ Age of first menses _____ Duration of periods _____days, cycle ____ days
Do you practice birth control ? ☐ Yes ☐ No . If yes, what type and for how long? _____
If you're on birth control pills, what are you taking and for how long? _____

Male ☐ Prostate problems ☐ Discharge ☐ Impotence ☐ Frequent seminal emission
☐ Fertility problems ☐ Ejaculation problems ☐ Painful/swollen testicles ☐ Other

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I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Date: