

# Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential.

## GENERAL INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Gender  M  F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Phone:  Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_  
(please indicate preferred contact number)

Single  Married  Partnered  Widowed  Separated/Divorced

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relation \_\_\_\_\_

Emergency contact number: Home \_\_\_\_\_ Cell \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

Name of physician \_\_\_\_\_ Phone number \_\_\_\_\_  
(No contact will be made without your permission)

Your signature \_\_\_\_\_ Have you received acupuncture previously?  Yes  No

## WHAT BRINGS YOU HERE

What health concerns bring you into our office for treatment? \_\_\_\_\_

\_\_\_\_\_

When did you first notice your symptoms? \_\_\_\_\_

What other forms of treatment have you sought? \_\_\_\_\_

## LIFESTYLE HABITS

Alcohol (drinks per week) \_\_\_\_\_ Coffee/Tea (cups per day) \_\_\_\_\_ Soda (regular or diet) \_\_\_\_\_

Cigarettes (packs per day) \_\_\_\_\_ Drug use (recreational) \_\_\_\_\_

What does your diet consist of? \_\_\_\_\_

List any allergies, food sensitivities or food cravings that you have: \_\_\_\_\_

Exercise  Yes  No How often? \_\_\_\_\_

What kind of exercise? \_\_\_\_\_

**FAMILY HISTORY** — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self	mother	father	sibling	spouse/partner	children
Adopted						
Good Health						
Alcohol or other drug use						
Depression or mental illness						
Allergies						
High blood pressure/heart disease/stroke						
Cancer or tumors						
Diabetes						
Seizures						
Hepatitis/other liver disorder						
HIV/AIDS						
Blood or bleeding disorders/anemia						
Thyroid disorders						
Kidney disorders						
Deceased (age)	N/A					

**MEDICAL** If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

Year	Operation/Illness	Hospital or Treatment Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MEDICINES** Please list all medications, vitamins and/or food supplements you are currently taking:

Medications	Dosage & Frequency	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins & Supplements	Dosage & Frequency	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**CONDITIONS/SYMPTOMS** --- Please mark any condition you have experienced in the past or currently.

**Temperature**

- | <i>past</i>              | <i>current</i>           |                                    |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cold hands                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold fingers                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold feet                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold toes                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweaty hands                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweaty feet                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot overall                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Afternoon flushes                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat in the hands, feet, and chest |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Perspire easily                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of perspiration               |
| <input type="checkbox"/> | <input type="checkbox"/> | Take water to bed                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Thirst                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Strongly like cold drinks          |
| <input type="checkbox"/> | <input type="checkbox"/> | Strongly like hot drinks           |

**Energy**

- | <i>past</i>              | <i>current</i>           |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Low energy                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty keeping eyes open during day |
| <input type="checkbox"/> | <input type="checkbox"/> | General weakness                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Feel worse after exercise               |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily catch colds                      |

**Liver/Spleen/Heart Function**

- | <i>past</i>              | <i>current</i>           |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Nightmares                |
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy skin                |
| <input type="checkbox"/> | <input type="checkbox"/> | Sharp/stabbing fixed pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Dull moving pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in moles, lumps   |

**Heart Function**

- | <i>past</i>              | <i>current</i>           |                                  |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain traveling to shoulder |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Restlessness                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental confusion                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent dreams                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Wake unrefreshed                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Sores on the tip of the tongue   |

**Lung Function**

- | <i>past</i>              | <i>current</i>           |                                       |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Sneezing                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus congestion                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache, location: _____             |
| <input type="checkbox"/> | <input type="checkbox"/> | Nasal discharge, color: _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory allergies, to what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry nose                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry mouth                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry throat                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry skin                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff neck                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff shoulders                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Overall achy feeling                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Alternating chills & fever            |
| <input type="checkbox"/> | <input type="checkbox"/> | Sadness                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Melancholy                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Loneliness                            |

**Spleen Function**

- | <i>past</i>              | <i>current</i>           |                                     |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Low appetite                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Abrupt weight gain                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abrupt weight loss                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal bloating                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal gas                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Gurgling in stomach                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue after eating                |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily bruised                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolapsed organs (diagnosed): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Pensive                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Over-thinking                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Worry                               |

**Spleen, Stomach, Large Intestine Function**

- | <i>past</i>              | <i>current</i>           |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Loose stools              |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipated               |
| <input type="checkbox"/> | <input type="checkbox"/> | Incomplete evacuation     |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in stools           |
| <input type="checkbox"/> | <input type="checkbox"/> | Mucous stools             |
| <input type="checkbox"/> | <input type="checkbox"/> | Undigested food in stools |

**Dampness**

- | <i>past</i>              | <i>current</i>           |                                |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | General sensation of heaviness |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental heaviness               |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental sluggishness            |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental fogginess               |
| <input type="checkbox"/> | <input type="checkbox"/> | Puffy hands                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Edema, location: _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweaty feet                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest congestion               |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Snoring                        |

**Stomach Function**

- | <i>past</i>              | <i>current</i>           |                                    |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Large appetite                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning sensation after eating     |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Acid regurgitation                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer (diagnosed)                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Belching                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Hiccups                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Bad breath                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth (canker) sores               |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding, swollen, or painful gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting                           |

**Eyes (Liver Function)**

- | <i>past</i>              | <i>current</i>           |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloodshot                |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Watery                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Gritty                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurry vision            |
| <input type="checkbox"/> | <input type="checkbox"/> | See floating black spots |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased night vision   |
| <input type="checkbox"/> | <input type="checkbox"/> | Near-sighted             |
| <input type="checkbox"/> | <input type="checkbox"/> | Far-sighted              |

**Mental/Emotional**

- | <i>past</i>              | <i>current</i>           |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Mood swings          |
| <input type="checkbox"/> | <input type="checkbox"/> | Compulsive behaviors |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty relaxing  |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty focusing  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensitive            |
| <input type="checkbox"/> | <input type="checkbox"/> | Shyness              |
| <input type="checkbox"/> | <input type="checkbox"/> | Suicidal thoughts    |

**Liver/Gall Bladder Function**

- | <i>past</i>              | <i>current</i>           |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Gall stones  |
| <input type="checkbox"/> | <input type="checkbox"/> | Bitter taste in mouth  |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions  |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rashes  |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache at top of head                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | High-pitched ringing in ears                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Lump (sensation) in throat                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck tension   |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck: Limited range-of-motion                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder tension   |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder: Limited range-of-motion                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling sensation   |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness   |
| <input type="checkbox"/> | <input type="checkbox"/> | Tight sensation, location: _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms  |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle twitching/tremors                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramping  |
| <input type="checkbox"/> | <input type="checkbox"/> | Anger easily   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frustration  |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability   |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hopeless outlook   |
| <input type="checkbox"/> | <input type="checkbox"/> | Lose temper  |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequently unable to adapt to stress; cause of stress: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease (s); specify: _____             |

**Kidney/Urinary Bladder Function**

- | <i>past</i>              | <i>current</i>           |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones               |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection           |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily broken bones         |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore knees                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Weak knees                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sensation in knees     |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back pain               |
| <input type="checkbox"/> | <input type="checkbox"/> | Low-pitched ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive hair loss         |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent cavities           |
| <input type="checkbox"/> | <input type="checkbox"/> | Loose adult teeth           |
| <input type="checkbox"/> | <input type="checkbox"/> | Wake frequently to urinate  |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of bladder control     |
| <input type="checkbox"/> | <input type="checkbox"/> | Fear                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily startled             |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory problems             |

**Urination**

- | <i>past</i>              | <i>current</i>           |                 |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Light Yellow    |
| <input type="checkbox"/> | <input type="checkbox"/> | Dark yellow     |
| <input type="checkbox"/> | <input type="checkbox"/> | Reddish         |
| <input type="checkbox"/> | <input type="checkbox"/> | Clear           |
| <input type="checkbox"/> | <input type="checkbox"/> | Cloudy          |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood           |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge       |
| <input type="checkbox"/> | <input type="checkbox"/> | Scanty          |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse         |
| <input type="checkbox"/> | <input type="checkbox"/> | Strong odor     |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful         |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult       |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgent          |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent        |
| <input type="checkbox"/> | <input type="checkbox"/> | Incomplete      |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinent     |
| <input type="checkbox"/> | <input type="checkbox"/> | Bedwetting      |
| <input type="checkbox"/> | <input type="checkbox"/> | Wake to urinate |

**Male ---- Genital**

- | <i>past</i>              | <i>current</i>           |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Impotence                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature ejaculation     |
| <input type="checkbox"/> | <input type="checkbox"/> | Nocturnal emission        |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/itching of genitalia |
| <input type="checkbox"/> | <input type="checkbox"/> | Lumps in testicles        |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased libido          |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased libido          |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (describe) _____    |

**Female ---Gynecology**

- | <i>past</i>              | <i>current</i>           |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Menopause              |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods      |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual cramps       |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive blood flow   |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual blood clots  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal pap smear     |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal infections     |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal pain/itching   |
| <input type="checkbox"/> | <input type="checkbox"/> | Uterine fibroids       |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis          |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness      |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast lumps, cysts    |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased libido       |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased libido       |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (describe) _____ |

Currently pregnant?  Yes  No

Trimester: \_\_\_\_\_

Past pregnancies:

# of live births: \_\_\_\_\_

# of miscarriages: \_\_\_\_\_

# of abortions: \_\_\_\_\_

**Other Information:**

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_