

**Vanessa Valdes, M.S.**  
Licensed Acupuncturist  
Licensed Physical Therapist  
422 Hudson St., New York, NY 10014  
Office: (212) 242-7807 Cell: (646) 673-2536

**CONFIDENTIAL MEDICAL INTAKE FORM**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ E-mail: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Living status:  Single  Married/Partnered  Widowed  Divorced

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had acupuncture before?  Yes  No

For what condition? \_\_\_\_\_

What condition would you like to address with acupuncture now?  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Onset was:  Sudden?  Gradual?

Symptoms are relieved by \_\_\_\_\_

Symptoms are made worse by \_\_\_\_\_

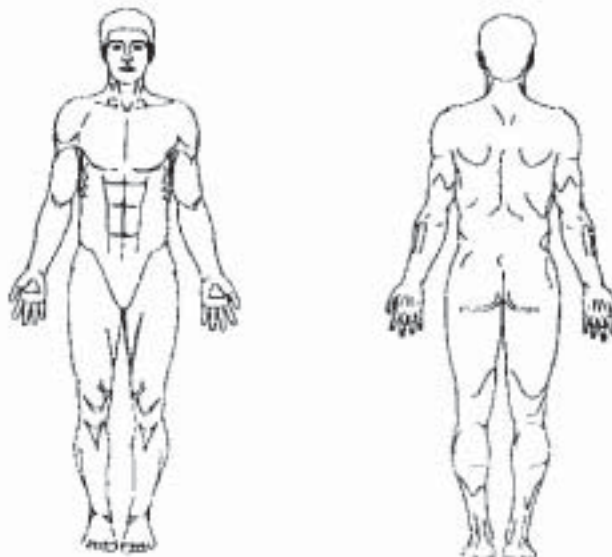
What medical diagnosis have you received? \_\_\_\_\_

What other treatments have you received for this and/or other conditions?  
\_\_\_\_\_  
\_\_\_\_\_

Are you taking any medication?  Yes  No

Please note all medications, herbs, vitamins and minerals you are currently taking, even if you take them only occasionally.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

On the drawings below, please shade in the areas of tension, pain, or discomfort.



---

**MEDICAL HISTORY**

**Birth:** Anything significant about your birth? \_\_\_\_\_

**Vaccination history:** Any reaction that you remember? Any unusual vaccination?

**Childhood illnesses:** Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

Age: \_\_\_\_\_ yrs. \_\_\_\_\_

Age: \_\_\_\_\_ yrs. \_\_\_\_\_

Age: \_\_\_\_\_ yrs. \_\_\_\_\_

**Adolescence illnesses:** Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

Age: \_\_\_\_\_ yrs. \_\_\_\_\_

Age: \_\_\_\_\_ yrs. \_\_\_\_\_

Age: \_\_\_\_\_ yrs. \_\_\_\_\_

**Adulthood:** Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

Age: \_\_\_\_\_ yrs. \_\_\_\_\_  
\_\_\_\_\_

Age: \_\_\_\_\_ yrs. \_\_\_\_\_  
\_\_\_\_\_

Age: \_\_\_\_\_ yrs. \_\_\_\_\_  
\_\_\_\_\_

**Family history:** please note all major illnesses in your immediate family such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Underline current conditions. Put a check mark in the box for former conditions. Add any additional information regarding duration, frequency, intensity and pain regarding current symptoms.

**Have you had any of these?**

- AIDS/HIV                       Cancer                       Lyme Disease                       Seizures
- Alcoholism                       Diabetes                       Multiple Sclerosis                       Tuberculosis
- Allergies                       Emphysema                       Pacemaker                       Polio
- Asthma                       Heart Disease                       Lymph nodes removed                       Rheumatic Fever
- Hepatitis A/B/C                       Scarlet Fever                       Headache                       Birth Trauma (your own)
- Herpes                       Other \_\_\_\_\_

**Diet and Food:**

How is your appetite?

- Good                       Poor                       No appetite                       Hungry all the time

Any food cravings? \_\_\_\_\_

List any food intolerances: \_\_\_\_\_

Describe meals for a typical day: Breakfast \_\_\_\_\_

Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_

How often do you have: meat \_\_\_\_\_ x per day/wk Coffee or Tea (caffeinated) \_\_\_\_\_ x per day/wk

Sugar/Sweets \_\_\_\_\_ x per day/wk Dairy (milk, cheese, yogurt) \_\_\_\_\_ x per day/wk

Are you always thirsty?  Yes  No Do you prefer a beverage to be:  Hot  Cold

How many glasses/cups do you have daily: Water \_\_\_\_\_ x per day, soda \_\_\_\_\_ x per day,

Coffee/Tea \_\_\_\_\_x per day/wk. Alcohol \_\_\_\_\_per day/wk

Do you have unusual sweating? When? \_\_\_\_\_ other \_\_\_\_\_

Rate your taste preferences 1 to 5 (1=like most to 5=dislike):

Salty\_\_\_\_\_ Sour\_\_\_\_\_ Bitter\_\_\_\_\_ Sweet\_\_\_\_\_ Spicy\_\_\_\_\_

---

### Exercise and Energy:

How is your energy?\_\_\_\_\_

What time of day is your energy: Highest? \_\_\_\_\_ Lowest \_\_\_\_\_

Do you fatigue easily? \_\_\_\_\_

Does movement make you feel:  Less tired  More tired

What kind of exercise do you do? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

---

### Emotions and Sleep:

How do you feel emotionally?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have (check all that apply):

- Panic attacks  Depression  Anxiety  Bad Temper  
 Nervousness  Fear attacks  Poor memory  Difficult concentration  
 Other: \_\_\_\_\_

Are you:  Married or in a stable relationship  Single

How do you feel about your relationship?\_\_\_\_\_

How do you hold stress?\_\_\_\_\_

How do you relax? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

Do you use any prescription or non-prescription substances?  Anti-depressants  Sleeping pills

Other: \_\_\_\_\_

How long do you normally sleep? \_\_\_\_\_ hours per night

I have difficulty with (check all that apply):

- Falling asleep  Staying asleep  Disturbed Sleep

Waking up at about \_\_\_\_\_am/pm and not being able to fall asleep again because

\_\_\_\_\_

**Skin and Hair:**

I have (check all that apply):

- Dry skin                       Skin rashes                       Itching                       Acne  
 Eczema                       Hives                       Hair loss                       Premature graying  
 Other: \_\_\_\_\_
- 

**Respiratory, Eyes, Ears, Nose, Throat & Head:**Do you smoke?  Yes  No If yes, \_\_\_\_\_ per day, for \_\_\_\_\_ years

I have (check all that apply):

- Frequent colds                       Chronic runny nose                       Chronic cough                       Coughing blood  
 Pain inhaling                       Shortness of breath on exertion/at rest                       Asthma  
 Nose bleeds                       Pain/red eyes                       Poor vision                       See spots  
 Dizziness                       Cold sores                       Bleeding gums                       Dry mouth  
 Ear pain                       Ringing in ears                       Clogged/popping ears                       Frequent sore throat  
 Cough up mucous How much? \_\_\_\_\_ Color of phlegm? \_\_\_\_\_  
 Frequent headaches/migraines

Describe: \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

**Cardiovascular:**Blood pressure: \_\_\_\_\_/\_\_\_\_\_ Have you been diagnosed with heart trouble?  Yes  No

I have (check all that apply):

- Chest pain                       Palpitations                       Irregular heart beat                       Phlebitis  
 Varicose veins                       Cold hands/feet                       Poor circulation
- 

**Gastrointestinal:**

I have (check all that apply):

- Belching                       Nausea                       Vomiting                       Vomiting of blood  
 Ulcers                       Acid regurgitation                       Heartburn                       Hernia  
 Indigestion                       Severe stomach pains  
 Other : \_\_\_\_\_

Bowel movements: How often? \_\_\_\_\_ day/week

Painful bowel movement?  Yes  No

I have (check all that apply):

- |                                       |                                       |   |   |
|---------------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> Irregularity | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Gas                      |
| <input type="checkbox"/> Burning      | <input type="checkbox"/> Hemorrhoids  | <input type="checkbox"/> Use laxatives  | <input type="checkbox"/> Undigested food in stool |
| <input type="checkbox"/> Loose stool  | <input type="checkbox"/> Hard stool   | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Itchiness                |
| <input type="checkbox"/> Other: _____ |                                       |   |   |
- 

### Muscles, Joints and Bones:

Do you have pain or tightness? Where? \_\_\_\_\_

The pain is (check all that apply):

- |   |   |   |                                    |
|---|---|---|------------------------------------|
| <input type="checkbox"/> Sharp                          | <input type="checkbox"/> Aching                         | <input type="checkbox"/> Numb             | <input type="checkbox"/> Deep pain |
| <input type="checkbox"/> Burning                        | <input type="checkbox"/> Dull                           | <input type="checkbox"/> Superficial pain | <input type="checkbox"/> Tingling  |
| <input type="checkbox"/> Pain worse or better with heat | <input type="checkbox"/> Pain worse or better with cold |   |                                    |
| <input type="checkbox"/> Pain worse in am or pm         |   |   |                                    |

I have (check all that apply):

- |   |   |                                      |  |
|---|---|--------------------------------------|--|
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Arthritis/joint pain | <input type="checkbox"/> Tendinitis  | <input type="checkbox"/> Rheumatism        |
| <input type="checkbox"/> Bone pain      | <input type="checkbox"/> Muscle cramping      | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Repetitive strain |
| <input type="checkbox"/> Other: _____   |   |                                      |  |
- 

### Urinary & Genital:

Urination: How often? \_\_\_\_\_ times per day. Color.  Pale yellow  Dark yellow/orange

I have or have had (check all that apply):

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Trouble starting | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incontinence            | <input type="checkbox"/> Trouble holding urine    |
| <input type="checkbox"/> Pain             | <input type="checkbox"/> Burning            | <input type="checkbox"/> Dribbling when sneezing | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Blood in urine   | <input type="checkbox"/> Kidney stones      |  |   |
| <input type="checkbox"/> Other: _____     |   |  |   |

How is your sexual energy? \_\_\_\_\_

What kind of birth control do you use? \_\_\_\_\_

Do you have (check all that apply):

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Pain during sexual relation |
|--------------------------------------|--|

Other: \_\_\_\_\_

**Women:**

At what age did you start menstruation? \_\_\_\_\_ Number of days between cycles: \_\_\_\_\_

Number of days of flow: \_\_\_\_\_ Color: \_\_\_\_\_

I have or have had (check all that apply):

- Irregular menstruation       Heavy flow       Light flow  
 No flow       Clots       Vaginal itching/burning  
 Spotting between periods       Discomfort/pain before period       Discomfort/pain during period

Other: \_\_\_\_\_

Any vaginal discharge?  Yes  No

Amount \_\_\_\_\_ Color \_\_\_\_\_ Frequency \_\_\_\_\_

Have you had any of the following (check all that apply):

- Lumps in the breast       Congested breast       Breast tenderness  
 Blood or mucous discharge from breasts?

Amount \_\_\_\_\_ Frequency \_\_\_\_\_

PMS symptoms: \_\_\_\_\_

What makes these symptoms better? \_\_\_\_\_

Are you using birth control?  Yes  No If yes, what type \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_ Number of deliveries? \_\_\_\_\_ Abortion(s)/Miscarriage(s)? \_\_\_\_\_

Pregnancy complications? Please describe: \_\_\_\_\_

Menopausal Symptoms: \_\_\_\_\_

Reduced sexual energy?  Yes  No

**Men:**

I have (check all that apply):

- Prostatitis       Impotence       Penis blood/mucous discharge  
 Pain associated with genitals       Premature ejaculation       Reduced sexual energies  
 Seminal emission

Other: \_\_\_\_\_