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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

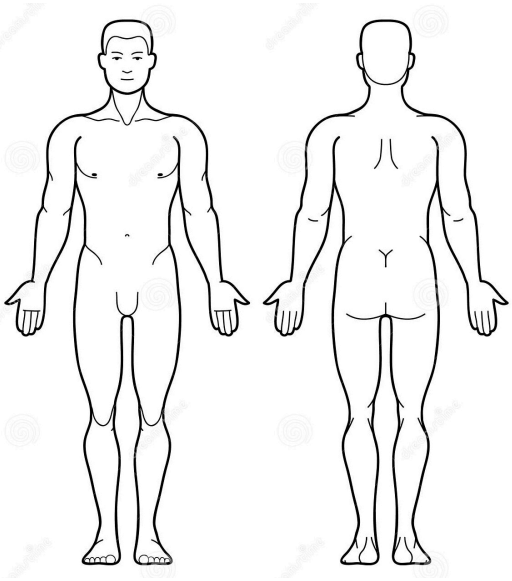
Please note all medications, herbs, vitamins and minerals you are currently taking, even if you take them only occasionally.

_____

_____

_____

On the drawings below, please shade in the areas of tension, pain, or discomfort. You may also describe these areas in writing in the lines provided.



_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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	☐ Headache	☐ Scarlet fever	☐ 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):

- ☐ Irregularity ☐ Constipation ☐ Diarrhea ☐ Gas
- ☐ Burning ☐ Hemorrhoids ☐ Use laxatives ☐ Undigested food in stool
- ☐ Loose stool ☐ Hard stool ☐ Blood in stool ☐ Itchiness
- ☐ Other: _____

Muscles, Joints and Bones:

Do you have pain or tightness? Where? _____

The pain is (check all that apply):

- ☐ Sharp ☐ Aching ☐ Numb ☐ Deep pain
- ☐ Burning ☐ Dull ☐ Superficial pain ☐ Tingling
- ☐ Pain worse or better with heat ☐ Pain worse or better with cold
- ☐ Pain worse in am or pm

I have (check all that apply):

- ☐ Swollen joints ☐ Arthritis/joint pain ☐ Tendinitis ☐ Rheumatism
- ☐ Bone pain ☐ Muscle cramping ☐ Muscle pain ☐ Repetitive strain
- ☐ Other:_____

Urinary & Genital:

Urination: How often? _____ times per day. Color. ☐ Pale yellow ☐ Dark yellow/orange

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

- ☐ Trouble starting ☐ Frequent urination ☐ Incontinence ☐ Trouble holding urine
- ☐ Pain ☐ Burning ☐ Dribbling when sneezing ☐ Urinary tract infections
- ☐ Blood in urine ☐ Kidney stones
- ☐ Other: _____

How is your sexual energy? _____

What kind of birth control do you use? _____

Do you have (check all that apply):

- ☐ Infertility ☐ 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: _____