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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

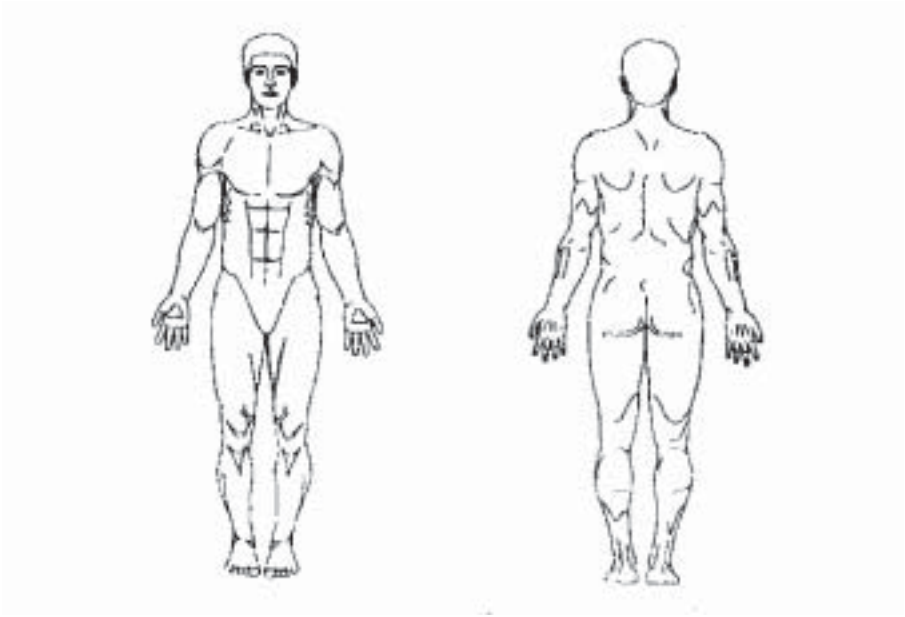
Please note all medications, herbs, vitamins and minerals you are currently taking, even if you take them only occasionally.

_____

_____

_____

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



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):

❑ 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: _____