gentle acupuncture

CONFIDENTIAL INTAKE FORM

DATE: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Preferred Pronoun: _____ Age: _____

Home Address: _____

_____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Occupation: _____

HEALTH HISTORY

I. Have you received acupuncture treatment before? YES NO

- If yes, for what conditions and what was the outcome?

II. WHAT IS IT THAT YOU WANT TREATED WITH ACUPUNCTURE?

A. Please describe your PRIMARY problem or health concern in your own words? How long have you had this problem, and was the onset sudden or gradual? Was there any significant event that led to it?

B. Please describe OTHER problems or health concerns in your own words? How long have you had this problem(s), and was the onset sudden or gradual? Was there any significant event that led to it?

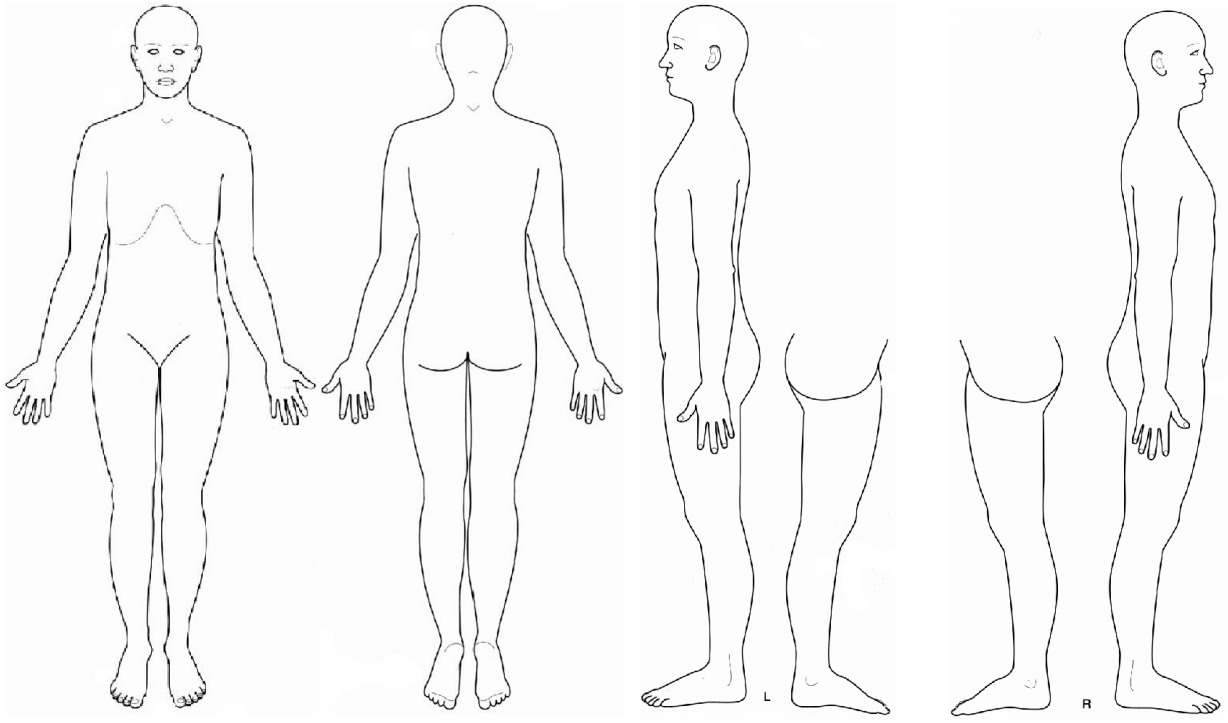
C. Please describe your goals, hopes and expectation for your acupuncture treatment:

D. Have you had a medical evaluation for your problem(s)? If yes, when and what diagnosis did you receive?

E. Other Care: What other therapies are you doing/ have you done to manage for your condition, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

III. WHERE IS YOUR PROBLEM?

Using the diagram, please shade in the areas where you feel symptoms associated with your complaints.



MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are CURRENTLY taking:

Medications, supplements, or herbs:	For what problem or concern:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____

LIST ANY ALLERGIES (to medications, supplements, herbs): _____

_____

IV. PERSONAL MEDICAL HISTORY

II. **BIRTH:** Describe anything significant/traumatic about your birth:

III. **VACCINATION HISTORY:** Any unusual reaction? Any unusual vaccination?

IV. **CHILDHOOD ILLNESSES (0-12 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:_____ _____

AGE:_____ _____

AGE: _____ _____

V. **ADOLESCENCE ILLNESSES (13-17 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:_____ _____

AGE:_____ _____

AGE: _____ _____

IV. **ADULTHOOD ILLNESSES (18 – 35 YEARS):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:_____ _____

AGE:_____ _____

AGE: _____ _____

IVI. **ADULTHOOD ILLNESSES (36 & up):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:_____ _____

AGE:_____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

V. FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER_____

FATHER_____

SIBLINGS_____

MATERNAL GRANDPARENTS_____

PATERNAL GRANDPARENTS_____

VI. SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY

MUSCULOSKELETAL

☐ Joint clicking
☐ Limitation of movement
☐ Pain or Stiffness
☐ Spasms or cramps
☐ Swelling
☐ Weakness
(WHERE?):

_____

EYES, EARS, NOSE & THROAT

Loss of vision, eye pain, tearing
Ear pain, loss of hearing, Ringing
Problems with balance (vertigo)
Olfaction (sense of smell) impaired
Nose stuffiness, nosebleeds, sinus pain
OTHER (Please list)

_____
_____

RESPIRATORY

Chest pain, tightness
Coughing up blood (hemoptysis)
Shortness of breath (dypsnea)
Sore throat
Sputum production
Wheezing
OTHER (Please list)

_____
_____

CARDIOVASCULAR

Chest pain &/or pressure
Edema
Fainting (syncope)
Fatigue
Palpitations
Skin ulceration
Swelling of the ankles &/or legs
OTHER (Please list)

_____
_____

DIGESTIVE

Abdominal distention/bloating
Abdominal mass
Abdominal pain
Acid regurgitation &/or Heartburn
Alternating constipation/diarrhea
Rectal bleeding
Constipation
Diarrhea
Gas
Eating disorder
Indigestion

DIGESTIVE

Jaundice (yellow tint to skin &/or eyes)
Nausea
Vomiting
OTHER (Please list))

_____

UROGENITAL

Difficulty with urine flow
Incontinence
Painful urination, pelvic pain
Rashes
Red urine
Urinary tract infection (UTI)
OTHER (Please list)

_____
_____

NEUROLOGICAL

Changes in consciousness
Confusion
Difficulty concentrating
Dizziness
Dysphasia (impaired ability to speak)
Gait disturbance, balance issues
Headache
Numbness and/or tingling
Loss of consciousness
Paralysis
Post shingles pain
Problems coordinating movements
Severe forgetfulness
Tremor
Visual disturbance
Weakness
OTHER (Please list)

_____
_____

INTEGUMENTARY (SKIN)

Changes in hair
Changes in nails
Changes in skin color
Itching
Never sweat
Rash and/or skin lesion
Unusual sweating
Wounds that will NOT heal
OTHER (Please list)

_____
_____

PSYCHOLOGICAL

Feelings of grief
Feeling of sadness
Feeling fearful/anxious/nervous
Difficulty managing anger

☐ Feeling manic
☐ Feeling worried or overly pensive
☐ Feelings of panic
☐ Feeling overwhelmed
☐ Extreme mood swings
☐ Extreme lack of emotion
☐ OTHER (Please list)

_____
_____

SLEEP

☐ Difficulty falling asleep
☐ Dream disturbed sleep
☐ Wake up & cannot fall back asleep
☐ OTHER (Please list)

_____
_____

MISCELLANEOUS

A C F Extremely low energy/fatigue
A C F OTHER (Please list)

_____
_____

FOR MEN ONLY

Unusual discharge
Fertility concerns
Prostate problems
Sexual dysfunction
OTHER (Please list)

_____
_____

FOR WOMEN ONLY

Abnormal vaginal bleeding
Changes in hair distribution
Fertility concerns
Irregular menstruation
Menopausal symptoms
No menses
Pain with menses
Pain during or after sexual relations
Pelvic pain
Premenstrual symptoms
Sexual dysfunction
Unusual discharge
OTHER (Please list)

_____

Are you pregnant OR trying to become pregnant?
YES NO

Have you ever been pregnant? YES NO If yes, how many pregnancies: _

Births ____
Miscarriages ____
Abortions ____

VII. MEDICAL DISEASES/CONDITIONS

WHAT MEDICAL DISEASES/CONDITIONS HAVE BEEN DIAGNOSED?

HEART

LUNG

DIGESTIVE SYSTEM

URINARY SYSTEM

BONES AND JOINTS

SKIN

FACE & HEAD

NECK AND THYROID

UPPER EXTREMITIES

LOWER EXTREMITIES

VIII. LIFESTYLE INFORMATION

A. Stress, Energy Level & Sleep

1. Do you think that stress, including recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:

2. Do you have any problems with your energy level? If yes, please briefly describe:

3. Do you have any problems with sleep? If yes, please briefly describe:

4. Do you have any problems with your sexual drive? If yes, please briefly describe:

B. Smoking, Alcohol & Drugs

1. Do you smoke tobacco? YES NO If yes, do you believe that this is a problem for you?

2. Do you drink alcohol? YES NO If yes, do you believe that this is a problem for you?

3. Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO Do you believe that this is a problem for you?

C. Diet and Nutrition

1. If applicable, briefly describe any problems you think you have with your eating habits and appetite. Do you believe that your diet has any impact on your complaints? YES NO

2. Are you concerned about your weight and/or appetite (under or overweight, too much or too little appetite)? YES NO