



Acupuncture & Oriental Medicine

Intake Form

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Please complete all the fields below as accurately as possible, even if you feel certain questions don't pertain to your current condition. All information is kept confidential. Thank You.

Name _____ Date of Birth _____ / _____ / _____ Gender F ___ M ___

Address _____ City _____ State _____ Zipcode _____

Height _____ Weight _____ LB Occupation _____ Referred by _____

Phone number you would like received call from us (Day) (_____) _____ - _____

(Evening) (_____) _____ - _____ Email _____

Your medical doctor's name & phone number: _____

Emergency contact name & phone number: _____

1. What is (are) your primary reason(s) for this visit?

1) _____ 2) _____

2. What initiates your symptoms? When had it started?

3. Have you been given a diagnosis for this problem? If so, what? _____

4. What kinds of treatment have you tried? _____

5. What makes them better? _____ What makes them worse? _____

Please indicate if any of the following apply to you:

Hemophiliac

Pacemaker

Heart Condition

Anticoagulant Use

Epilepsy/Seizures

Vegetarian/Vegan

Lung Condition

Stroke

HIV/AIDS

Hepatitis

Cancer

Diabetes

Are you pregnant/is there a chance that you are pregnant?

Yes No

Medications (please list any *prescribed or over-the-counter medications or supplements* that you are currently taking or have taken in the past three months):

Medications	Dosage and frequency/ How long did you take it	Reason for taking	Side effect (if any)

Past Medical History

Illnesses: _____
Surgeries _____

Significant Trauma (Auto accidents, falls, etc.) _____

Do you have, or have you ever had, any Infectious Diseases? Yes No F
If so, please describe _____

allergies :Please list tested or suspected allergies and related symptoms:
Foods _____ Drug / other _____
Seasonal _____

Family History

Check illnesses that have occurred in any of your blood relatives:

Alcoholism	Bleed Easily	Diabetes	Obesity	Kidney disease	Mental illness
Allergy	Heart Disease	Cancer	Epilepsy	High blood pressure	Stroke

Other: _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE MONTHS)

Diet

Are you on a restrictive diet? Yes No Condition diet is meant to treat: _____

Style/Type of diet: _____

of meals eaten in average day: _____ Estimated oz of water/day: _____

Do you consider your diet "healthy"? Very Somewhat No
Caffeine Intake: None Coffee Tea Cola/performance drinks # of cups/cans per day: _____

Consume alcohol: No Yes Type of alcohol consumed: _____ # of drinks/week: _____

Tobacco Use: Yes No Cigarettes: Packs/day _____ Chew: #/day _____
Pipe/cigar#/day _____ # of years used: _____

Recreational Drug Use: Yes No Type of Drug: _____ Frequency: _____

General

Always feel hot	Always feel cold	Cold only hands/feet	Fever & Chills
Night Sweats (head/body/extremities)		Day Sweating	Hot Flash

Temp of drinks/food most commonly desired: Very cold Tepid Very Hot
of Energy Level (0-10)? _____ Sudden energy drops? What time of Day? _____
Chronic Fatigue Anemia

Cardiovascular:

Heart palpitations	Irregular heart beat	Poor circulation	Varicose veins
Chest pain/tightness	Swelling feet/ankles	High blood pressure	Low blood pressure

History of heart attack _____
Other: _____

Respiratory

Cough	Pain w/ Deep Breaths	Shortness of Breath	Wheezing/Asthma
Bronchitis	Coughing Blood	Production of phlegm	Color (white/yellow/green/_____)
Sinus mucus	Chronic sinus infection	Frequent Colds	Hay fever/allergies
Nose bleeding	Nasal congestion	Dry nose	Other: _____

Head & Neck

Dizziness/Vertigo	Fainting	Stiff neck	Cataracts
Headache	Migraine	Poor Memory	Glaucoma
Blurred vision	Visual changes	Spots/floaters	Eye pain
Dry/red/itching/eyes	Poor night vision	E arache	Red/burning/itching eyes
Chronic ear infection	Decreased hearing	Ringin g in ears	Pitch High low
Facial pain			

Other: _____

Mouth & Throat:

Bleeding gums	Recurrent sore throat	Enlarged lymph glands
Dry mouth	Tongue/Mouth sores/ulcers	Difficulty swallowing
Bitter /metal/ bland /sweet taste in mouth		Other: _____
TMJ	Loss of voice	Gum problems

Gastrointestinal

Excessive hunger	Hunger w/no desire to eat	Poor appetite	Specific cravings
Excessive thirst	Thirst w/no desire to drink	No thirst	Mucous in stool
Diarrhea	Abdominal Pain/ Cramps	Constipation	Loose/soft stool
Alternating diarrhea/constipation		do not feel complete aftern stool	
Bloating/gasing	Belch/Acid reflux/heartburn	Bad Breath	Gallbladder disorder
Blood in Stools	Nausea/Vomiting	Anal fissures	Hemorrhoids
Rectal pain/itchiness	Laxative use	Parasites	Hiccups
Recent unexplained weight changes	Hernia	Ulcers	Other: _____

Genito-urinary

Water Output=Input? Yes No	Color of Urine	Clear/ slight yellow/ dark yellow
Painful/burning urination	Excessive or scant urination	Frequent Urination
Urgent Urination	Unable to Hold Urine when jumping/coughing	
UnrineDribbling/ Retention	Waking up to Urinate How often?	_____
Blood in Urine	Bedwetting	Genital Sores
Kidney Stone	Kidney sores	Impotency/ Infertility
I ncreased libido	D ecreased libido	Other: _____

Skin:

Hives/Rashes	A cne	E czema/psoriasis	Dry skin
Bruise easily	C hanges in moles/lumps	B rittle/weak nails	I tchy skin

Other: _____

Sleep:

Time to Bed: _____ Time to Wake: _____ # hours sleep _____

Sound/restful	Trouble falling asleep	Trouble staying asleep	Wake easily/early
Dream disturbed	Vivid dreams/nightmares	Difficulty waking up	
Poor Sleep/ Insomnia	Dream Disturbed Sleep	Other: _____	

Emotions:

Relaxed/calm	Sad/Grief/depressed	Fearful	Impatient
Anxious	Easily Angered /Frustrated	Forgetful/poor memory	Stressed
Depression	Manic	Other: _____	
Have you ever considered or attempted suicide?		Yes	No

Exercise:

Mostly sedentary (little to no activity in career/home)
 Mild exercise (housework, climb stairs, gardening etc)

Occasional vigorous exercise (moderate manual labor, exercise <4x/week for 30 min)
 Regular vigorous exercise (hard manual labor, exercise >4x/week for 30 min)
 Extreme exercise (professional athlete, serious amateur athlete, exercise 6-7x/week for >45 min)

For Women Only

First day of last period: _____ Approx date/year menopause: _____
 Date of Last Pap Smear _____/_____/_____
 Age at first Menses: _____ # of days in cycle _____ Duration of Menses _____
 Color of Bleeding pink red dark red with clots
 Irregular Periods Painful Periods Excessive flow Scant flow
 Cramping Mid-cycle spotting PMS Breast Lumps
 Birth control pill Vaginal Discharge yellow/white Vaginal Sores
 Uterine fibroids: Endometriosis:
 # of pregnancies _____ #of live births _____ Difficult Births
 Miscarriages How long? _____

For Men Only

large Prostate Sexual Dysfunction Infertility

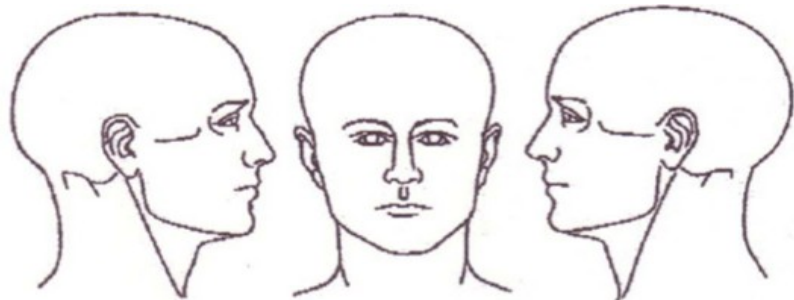
Musculoskeletal

Joint pain	Body aches/stiffness	Muscular Weakness	Numbness/tingling
Muscle Spasm	Arthritis	Injuries or Falls	Recent Sprains
Muscular Atrophy	Joint Instability	Joint swelling	Joint discoloration
“Heaviness” of body/limbs	Limited range of motion		
Other: _____			

If your chief complain is pain, what is pain level from 0-10 ? (0 means no pain at all) _____
 Additional Comments:

The Pain is

Sharp	Dull
Aching	Burning
Deep Pain	Superficial Pain
Numb	Tingling
Shooting	
Pain worse with cold	
Pain worse with hot	
Pain better with pressure	
Pain worse in Am/PM/night	



I have (check all that apply)

Swollen Joint
 Muscle pain
 Muscle cramping
 Joint Pain
 Stain Injury
 Bone Pain
 Fracture Bone
 Tendonitis

