Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION:

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Date of Birth _____ Age _____ Email _____

Single _____ Married _____ Separated/Divorced _____ Widowed _____ Partnered _____

Height _____ Weight _____ Education _____

Occupation: _____

Emergency contact _____ Relation _____

Emergency contact telephone: Home ( ) _____ Cell ( ) _____

Name of Physician * _____ Phone Number ( ) _____

Address _____

Date of last Full Physical Assessment _____

Name of Counselor/Psychologist * _____ Phone Number ( ) _____

Address _____

Date of last counseling Session _____

(For Women Only) Name of Gynecologist * _____ Phone Number ( ) _____

Address _____

Date of last Gynecological Exam _____

**** No contact will be made with the physician without your permission.***

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? Yes/ No

Special Problems or Symptoms _____

_____

_____

_____

Your Signature: _____ **Date:** _____

FAMILY HISTORY – Please complete for each family member, as best you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse	Children
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure/heart disease						
Stroke						
Blood or bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol/Drug abuse						
Depression or mental illness						
Hepatitis/other Liver Disorder						
Musculo-skeletal disorder						
HIV/AIDs						
Blood transfusion (if before 1985)						
Deceased (age)	N/A					

PERSONAL LIFESTYLE HABITS: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs per day)	Coffee/Tea (cups per day)
Alcohol (drinks per week)	Soda (regular or diet)
Drug Use (recreational)	Fast Food (times per week)

EXERCISE:

Types: _____ **Frequency:** _____

MEDICAL: If you have ever been hospitalized for a serious medical illness or operation, please write the most recent ones below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

MEDICINES: (please attach list (if needed) with all prescription drugs, OTC drugs, vitamins, herbs or other supplements)

What prescription drugs are you currently taking? Dosage? For what condition?

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

What over-the-counter medications, herbs, or supplements are you currently taking: Dosage? For what condition?

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS
Please put a **"C"** if the condition is current or a **"P"** if you had it in the past or **"P-C"** for both past and current conditions

General
__ Insomnia
__ Dreams/ nightmares
__ Fatigue
__ Poor memory
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Recent weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever
__ Other (describe)_____

_____

Head & Neck
__ Headaches
__ Migraines
__ Stiff neck
__ Dizziness
__ Fainting
__ Swollen glands
__ Other (describe)_____

_____

Ears
___Ringing
__ Hearing loss
__ Hearing aids
__ Infections
__ Earache
__ Vertigo
__ Other (describe)_____

_____

Eyes
__ Glasses/ contact lenses
__ Blurred vision
__ Poor night vision
__ Spots or floaters
__ Eye inflammation
__ Double vision
__ Glaucoma
__ Cataracts
__ Other (describe)_____

_____

Nose, Throat & Mouth
__ Sinus infection
__ Hay fever/ allergies
__ Frequent sore throat
__ Difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent colds
__ Nosebleed
__ Dry nose
__ Nasal congestion
__ Loss of voice
__ Thirst
__ Excessive phlegm
__ TMJ
__ Facial pain
__ Gum problems
__ Dry mouth
__ Other (describe)_____

_____

__ Dental Problems? Last Visit?

_____

Skin
__ Hives
__ Rashes
__ Eczema/ psoriasis
__ Night sweating
__ Excess sweating
__ Dry skin
__ Easily bruised
__ Changes in moles, lumps
__ Itching
__ Other (describe)_____

_____

Respiratory
__ Difficulty breathing
__ Wheezing
__ Asthma
__ Chronic cough
__ Wet cough
__ Dry cough
__ Coughing up phlegm
__ Coughing up blood
__ Shortness of breath
__ Tight chest
__ Pneumonia
__ Other (describe)_____

_____

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitation
__ Rapid heart beat
__ Irregular heart beat
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Anemia
__ History of heart attack
__ Other (describe)_____

_____

Gastrointestinal
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid regurgitation
__ Bloating
__ Bad breath
__ Laxative use
__ Bloody stool
__ Other (describe)_____

_____

Musculoskeletal
__ Joint pain/disorder
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Neck/shoulder pain
__ Upper back pain
__ Lower back pain
__ Rib pain
__ Limited range of motion
__ Other (describe)_____

_____

_____

_____

Neurological
__ Seizures
__ Tremors
__ Numbness or tingling
__ Pain (describe)
__ Paralysis
__ Poor coordination
__ Other (describe)_____

_____

Mental/Emotional
__ Depression
__ Mood swings
__ Irritability
__ Difficulty relaxing
__ Loneliness
__ Sensitive
__ Shy
__ Cry often
__ Worry a lot
__ Compulsive behaviors
__ Difficulty focusing
__ Hopeless outlook
__ Suicidal thoughts
__ Lose temper
__ Frustration
__ Other (describe)_____

_____

Urinary
__ Pain on urination
__ Frequent urination
__ Urgent urination
__ Blood in urine
__ Unable to hold urine
__ Incomplete urination
__ Bedwetting
__ Wake to urinate
__ Increased libido
__ Decreased libido
__ Kidney stones
__ Other (describe)_____

_____

Male Genital
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain/itching of genitalia
__ Lumps in testicles
__ Other (describe)_____

_____

Gynecology
__ Currently pregnant
__ # of Pregnancies
__ Miscarriages
__ Abortions
__ Menopause? (date) _____
__ Hormone replacement therapy
__ Irregular periods
__ Menstrual cramps
__ Excessive blood flow
__ Menstrual blood clots
__ Breast tenderness
__ Abnormal pap smear
__ Vaginal infections
__ Vaginal pain/itching
__ Uterine fibroids
__ Endometriosis
__ Breast lumps, cysts
__ Other (describe)_____

_____

Infection Screening (circle self and/or partner)
__ HIV risks: self or partner
__ TB: self or household
__ Hepatitis risk: self or partner
__ History of sexually transmitted disease: self or partner
__ Gonorrhea: self or partner
__ Chlamydia: self or partner
__ Syphilis: self or partner
__ Genital warts: self or partner
__ Herpes: self or partner
__ Other (describe)_____

_____

Trauma (list)

_____

_____

_____

Other Information

_____

_____

_____

Signature: _____ **Date:** _____