

**PATIENT INTAKE FORM**

Date \_\_\_\_\_

*About You*

Full Name _____		Sex	M	<input type="checkbox"/>	F	<input type="checkbox"/>
Date of Birth _____		Place & Time of Birth _____				
Street Address _____						
City _____		State _____		Zip Code _____		
Email _____						
Home Phone _____		Other Phone _____		Cell	<input type="checkbox"/>	Home <input type="checkbox"/> Work <input type="checkbox"/>
Emergency Contact _____				Phone # _____		
Marital Status		S	<input type="checkbox"/>	M	<input type="checkbox"/>	D <input type="checkbox"/> W <input type="checkbox"/>
Primary Physician/ Referring Physician _____						
How Did You Hear About Us? _____						

*About Your Concerns*

What would you like us to help you with? \_\_\_\_\_

Have you been given a diagnosis for your concern? Explain \_\_\_\_\_

When did the issue begin? \_\_\_\_\_

What are the precipitating factors? \_\_\_\_\_

What makes the concern worse? \_\_\_\_\_

What makes the concern better? \_\_\_\_\_

To what extent does this concern interfere with your daily activities? \_\_\_\_\_

What kinds of treatment have you tried for the concern? \_\_\_\_\_

Have you tried acupuncture before? \_\_\_\_\_

Does anyone in your family have the same concern? \_\_\_\_\_

*About Your Nutrition*

How many ounces of water do you drink a day? \_\_\_\_\_

How many caffeinated beverages a day? \_\_\_\_\_

How many alcoholic beverages a day? \_\_\_\_\_ A week? \_\_\_\_\_

Do you eat a special diet? Explain. \_\_\_\_\_

Please describe your average daily diet

Breakfast	_____	Lunch	_____
Dinner	_____	Snacks	_____

### *Additional Information About You*

Height \_\_\_\_\_ Weight \_\_\_\_\_

Weight (1 yr ago) \_\_\_\_\_ Weight (at Max) \_\_\_\_\_ When \_\_\_\_\_

Do you smoke? \_\_\_\_\_ What? \_\_\_\_\_ Since When? \_\_\_\_\_

Describe any use of drugs for non-medical purposes \_\_\_\_\_

Allergies? \_\_\_\_\_

Describe your exercise routine \_\_\_\_\_

How many hours do you sleep a night? \_\_\_\_\_ Time you go to bed? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Do you work indoors ☐ outdoors ☐

Occupational stressors? (chemical, physical, psychological) \_\_\_\_\_

What is your favorite season or type of weather? \_\_\_\_\_

Is any type of weather difficult for you physically or emotionally? \_\_\_\_\_

When you get out of balance emotionally, which describes your mood  
 worry/over thinking ☐ sadness/grief ☐ agitation/anxiety ☐  
 anger ☐ fear ☐

### *About Your Medical History*

List **medications** taken in the past 2 months: including **vitamins**, **over the counter remedies** and **herbs**.

Mark all of **Conditions** that apply, including **Year Diagnosed** and **Medication**

Year Diagnosed	Medicine	Year Diagnosed	Medicine
_____ Fibromyalgia	Y N	_____ Kidney	Y N
_____ Thyroid	Y N	_____ Ulcer	Y N
_____ HIV/AIDS Positive	Y N	_____ Arthritis	Y N
_____ Digestive	Y N	_____ Neuromuscular	Y N
_____ Breathing Problems	Y N	_____ Psychological Issues	Y N
_____ High Blood Pressure	Y N	_____ Hepatitis	Y N
_____ Cancer	Y N	_____ Seizures	Y N
_____ Venereal Disease	Y N	_____ Anemia	Y N
_____ Tuberculosis	Y N	_____ Gallbladder	Y N
_____ Heart	Y N	_____ High Triglycerides	Y N
_____ Lung/Pulmonary	Y N	_____ Osteoporosis	Y N
_____ Diabetes Mellitus	Y N		

## About Your Medical History Continued

List all of your **Surgeries, Hospitalizations** and **Significant Trauma's**

Year      Event


Check any additional **Symptoms** that apply to you & explain **Other**

<p><b>Head</b></p> <p>Headaches</p> <p>Migraines</p> <p>Dizziness</p> <p>Memory loss</p> <p>Concussions</p> <p>Other</p> <hr/> <p><b>Eyes</b></p> <p>Blurred Vision</p> <p>Pain</p> <p>Dryness</p> <p>Seeing Spots</p> <p>Redness</p> <p>Glasses/Contacts</p> <p>Eyestrain</p> <p>Color Blindness</p> <p>Night Blindness</p> <p>Cataracts</p> <p>Other</p> <hr/> <p><b>Ears</b></p> <p>Poor Hearing</p> <p>Ringing</p> <p>Frequent Infections</p> <p>Other</p> <hr/>	<p><b>Respiration</b></p> <p>Asthma</p> <p>Bronchitis</p> <p>Chest Pain</p> <p>Cough / Coughing Blood</p> <p>Emphysema</p> <p>Other</p> <p>Difficulty Breathing</p> <p>Phlegm</p> <p>Pneumonia</p> <p>Wheezing</p> <p>Other</p> <hr/> <p><b>Heart and Thorax</b></p> <p>Palpitations</p> <p>Rapid Heart Beat</p> <p>High Blood Pressure</p> <p>Low Blood Pressure</p> <p>Tightness in Chest</p> <p>Arteriosclerosis</p> <p>Heart Attack</p> <p>Other</p> <hr/> <p><b>Circulation</b></p> <p>Bruise Easily</p> <p>Cold Hands and Feet</p> <p>Fainting</p> <p>Anemia</p> <p>Phlebitis</p> <p>Varicose Veins</p> <p>Other</p> <hr/>	<p><b>Gastrointestinal</b></p> <p>Poor appetite</p> <p>Bad Breath</p> <p>Excessive Hunger</p> <p>Excessive Thirst</p> <p>Belching or Heartburn</p> <p>Colitis or IBS</p> <p>Gas</p> <p>Abdominal Pain</p> <p>Parasites</p> <p>Nausea</p> <p>Constipation</p> <p>Diarrhea</p> <p>Chronic Laxative Use</p> <p>Blood In Stools</p> <p>Black Stools</p> <p>Hemorrhoids</p> <p>Stomach Pain</p> <p>Rectal Pain</p> <p>Other</p> <hr/> <p><b>Emotional</b></p> <p>Depression</p> <p>Mania / Bipolar</p> <p>Anxiety</p> <p>Temper</p> <p>Mood Swings</p> <p>Stressed</p> <p>Other</p> <hr/>
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## About Your Medical History Continued

Check any additional **Symptoms** that apply to you & explain **Other**

<b>Mouth</b>	<b>Skin</b>	<b>Sleep</b>
<input type="checkbox"/> Gum Problems	<input type="checkbox"/> Rashes	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Teeth Problems	<input type="checkbox"/> Change in texture	<input type="checkbox"/> Drowsiness
<input type="checkbox"/> Tongue / Lip Sores	<input type="checkbox"/> Dryness	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Jaw Clicking / Pain	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Sleep Walking
<input type="checkbox"/> Unusual Tastes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Excessive Dreaming
<input type="checkbox"/> Other	<input type="checkbox"/> Hairloss	<input type="checkbox"/> Other
<b>Energy Level</b>	<input type="checkbox"/> Sweating	<b>Women's Issues</b>
<input type="checkbox"/> Low Energy	<input type="checkbox"/> Hives	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Excessive Energy	<input type="checkbox"/> Itching	<input type="checkbox"/> Cramps / Backache
<input type="checkbox"/> Hard to Wake Up	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fertility Problems
<input type="checkbox"/> Energy Drop in the PM	<input type="checkbox"/> Pimples	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Sudden Energy Drop	<input type="checkbox"/> Purpura	<input type="checkbox"/> Excessive Flow
<input type="checkbox"/> Other	<input type="checkbox"/> Recent Moles	<input type="checkbox"/> Endometriosis
<b>Neuromuscular/Skeletal</b>	<input type="checkbox"/> Other	<input type="checkbox"/> Low Sex Drive
<input type="checkbox"/> Stiff Neck	<b>Throat</b>	<input type="checkbox"/> Light Flow
<input type="checkbox"/> Low Back Soreness	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Clotting
<input type="checkbox"/> Shoulder Trouble	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> Thyroid Issues	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Other	<input type="checkbox"/> Discharge
<input type="checkbox"/> Knee Trouble	<b>Nose</b>	<input type="checkbox"/> Fibrocystic Breasts
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Breast Tenderness
<input type="checkbox"/> Painful Joints	<input type="checkbox"/> Sinus Troubles	<input type="checkbox"/> PMS
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drainage	<input type="checkbox"/> Low Sex Drive
<input type="checkbox"/> Hand / Wrist Pain	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Knee Pain	<b>Men's Issues</b>	<b>Urogenital</b>
<input type="checkbox"/> Sprain	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Hernia	<input type="checkbox"/> Discharge	<input type="checkbox"/> Difficult Urination
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Impotence	<input type="checkbox"/> Burning Urination
<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Frequent Emissions	<input type="checkbox"/> Itching of Genitals
<input type="checkbox"/> Other	<input type="checkbox"/> Fertility Problems	<input type="checkbox"/> Frequent UTI's
	<input type="checkbox"/> Ejaculatory Issues	<input type="checkbox"/> Waking to Urinate
	<input type="checkbox"/> Painful Testicles	<input type="checkbox"/> Pause of Flow
	<input type="checkbox"/> Swollen Testicles	<input type="checkbox"/> Retention of Urine
	<input type="checkbox"/> Other	<input type="checkbox"/> Dribbling of Urine
		<input type="checkbox"/> Bedwetting
		<input type="checkbox"/> Other

### *About Your Medical History Continued*

**Female Patients**, please answer the following:

Number of Pregnancies	_____	Number of Births	_____
Number of Miscarriages	_____	Number of Abortions	_____
Premature Births	_____	Cesarian Sections	_____
Age of First Mensus	_____	Duration of Periods	_____
Do you practice birth control	<input type="checkbox"/> No	<input type="checkbox"/> Yes,	Type _____

### *About Your Family Medical History*

Indicate the **items below**, if any, that apply to your family

	<i>Family Member</i>
Cancer	_____
Hypertension	_____
Alcoholism	_____
Diabetes	_____
Heart Disease	_____
Hepatitis	_____
Miscarriage	_____
Stroke	_____
Autoimmune Disease	_____
Asthma	_____
	_____

### *Your Informed Consent to Treatment*

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named within, for whom I am legally responsible) by the acupuncturist named within and / or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back up for the acupuncturist named within, including those working at the clinic or office listed within or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electric stimulation, TIU-NA (Chinese Massage), Chinese herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and the tea's consumed accordingly to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant affects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, infection, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and / or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member if I become pregnant. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

( Or Authorized Parent / Guardian if patient is under 18 )

**Print** \_\_\_\_\_