PATIENT INTAKE FORM
General Questionaire for Diagnosis and Therapy

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Even though some of the questions may seem unrelated to your condition, they may play a contributing role in diagnosis and treatment. Thank you for filling this out completely.

Contact Information

Today's Date: ___/___/___

Last Name: ________________ First Name: ________________ Sex F ☐ M ☐ Date of Birth: ___/___/___ Age: _____

Street: ________________________________ Email Address: ________________________________

City: _______________ State: _____ Zip: _______ Best Phone Number: ________________

Martial Status: M ☐ S ☐ D ☐ W ☐ # of Children _____ Occupation: ______________________

Have you had acupuncture before? Y ☐ N ☐

Major Health Complaint(s)

Please list in order of significance to you and circle which you would like us to focus on today.

1. ________________________________ 4. ________________________________

2. ________________________________ 5. ________________________________

3. ________________________________ 6. ________________________________

When did the circled problem begin? ________

What are the precipitating factors? ________________________________

Have you been given a diagnosis for this problem? If so, please describe. ______________________________

What kind of treatments have you tried? ____

What makes this problem worse? ______________________ Better? ______________________

Is there anybody in your family with the same problem?

____

Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

____

Past Medical History

Check any conditions that you have had in the past or are currently experiencing:

☐ Diabetes	☐ Vein Condition	☐ Thyroid Disorder	☐ Heart Disease	☐ Stroke
☐ Tuberculosis	☐ Asthma	☐ Pneumonia	☐ Profuse Bleeding or Hemorrhage	
☐ Blood Transfusion	☐ Jaundice	☐ Nervous Disorder	☐ Venereal Disease	☐ Epilepsy
☐ HIV	☐ Hepatitis	☐ Hypertension	☐ Auto Immune Disorder	☐ Migraines
☐ Anemia	☐ Mental Illness	☐ Cancer	☐ Liver Disease	☐ Hepatitis
☐ Kidney Disease	☐ Glaucoma	☐ Digestive Disorder	☐ Breathing Problems	☐ Arthritis

Other Conditions: ____________________

Known allergies (food or other): ____

Significant trauma (car accident, sports injuries etc.):______________________________

Immunizations: ____

Hospitalizations (procedures and dates): ____

Dental Procedures (include any silver fillings/mercury amalgams):____

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Do you have a history of frequent antibiotic use? Please Describe. ____________________

Do you/ have you in the past received allergy shots? Y ☐ N ☐

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc):

____

Family Medical History (please specify family member)

☐ Cancer ____________________ ☐ Diabetes ____________________
☐ Hepatitis ____________________ ☐ Hypertension ____________________
☐ Heart Disease ____________________ ☐ Stroke ____________________
☐ Asthma ____________________ ☐ Alcoholism ____________________
☐ Miscarriage ____________________ ☐ Other ____________________

Current Health & Lifestyle

Do you smoke? Y ☐ N ☐ If yes, how many per day? _____ For how long? _____

Do you exercise? Y ☐ N ☐ If yes, how many times per week? _____ Please Describe. ____________________

Do you travel frequently? Y ☐ N ☐ Have you traveled overseas/ to any 'developing' countries? Y ☐ N ☐

Do you sit in traffic/commute as a daily routine? Y ☐ N ☐

Height _____ Weight: Now _____ One year ago _____ Maximum _____ @ Year _____

How many hours do you sleep in general? _____ When do you usually go to bed? _____

List 3 things you do currently that support your overall health.

____
____
____

List your 3 favorite vices (eg smoking, social drinking, sweet tooth…)

____
____
____

Overall, do you feel that your lifestyle contributes to or takes away from your health?

____

Diet

_____ Soft drinks per day _____ Cups of tea per day _____ Cups of coffee per day _____ Glasses of water per day

_____ Alcoholic beverages per week.

Are you a vegetarian? Y ☐ N ☐ Yes, but not strict ☐

Please describe your average daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Please indicate painful or distressed areas:

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Medications and Supplements

Please list medicines you have taken within the last two months (including vitamins, supplements, over the counter drugs, herbs etc..): ______________________________

Profile

Please check any of the following symptoms that currently pertain to you.

Overall Body Temperature

- ☐ Cold hands
- ☐ Cold feet
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temperature
- ☐ Cold body temperature
- ☐ Afternoon flushing
- ☐ Hot flashes
- ☐ Profuse perspiration
- ☐ Lack of perspiration
- ☐ Night time urination
- ☐ Perspire easily
- ☐ Night sweating
- ☐ Strong thirst

Overall Energy

- ☐ Easily fatigued
- ☐ Shortness of breath
- ☐ Prone to illness
- ☐ Frequent colds/flus

Blood Function

- ☐ Dizziness
- ☐ Poor night vision
- ☐ Floaters
- ☐ Tingling in extremities
- ☐ Forgetfulness
- ☐ Difficulty concentrating
- ☐ Itchy or dry
- ☐ Scanty menses
- ☐ Fainting
- ☐ Blurry vision
- ☐ Tinnitus
- ☐ Weak nails

Heart Function

- ☐ Anxiety
- ☐ Manic moods
- ☐ Insomnia
- ☐ Heart palpitations
- ☐ Mental restlessness
- ☐ Restless dreams
- ☐ Forgetfulness
- ☐ Hallucinations
- ☐ Severe shyness
- ☐ Tongue ulcers
- ☐ Speech impediment
- ☐ Chest Pain

Lung Function

- ☐ Persistent cough
- ☐ Nosebleeds
- ☐ Sinus congestion
- ☐ Nasal dryness
- ☐ Chronic allergies
- ☐ Sore throats
- ☐ Dry or flaky skin
- ☐ Sneezing
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Difficulty Breathing

Spleen Function

- ☐ Indigestion
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Low or weak appetite
- ☐ Gurgling in intestines
- ☐ Bruise easily
- ☐ Fatigue following a meal
- ☐ Hemorrhoids
- ☐ Gas
- ☐ Hypoglycemia
- ☐ Strong cravings

Stomach Function

- ☐ Stomach ache
- ☐ Acid reflux
- ☐ Bad breath
- ☐ Ravenous appetite
- ☐ Bleeding gums
- ☐ Heartburn
- ☐ Stomach ulcer
- ☐ Belching
- ☐ Hiccups
- ☐ Nausea
- ☐ Vomiting
- ☐ Mouth ulcers

Bowel Function

- ☐ Loose stools
- ☐ Mucous in stools
- ☐ Blood in stools
- ☐ Difficulty moving bowels
- ☐ Less than 1 BM per day
- ☐ Small, hard, dry stools
- ☐ Constipation
- ☐ Diarrhea

Accumulated Dampness

- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Joint stiffness
- ☐ Mental fogginess
- ☐ Mental sluggishness
- ☐ Poor mental focus
- ☐ Edema in the legs
- ☐ Edema in the abdomen
- ☐ Chest congestion
- ☐ Heavy limbs/head

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Liver/Gall Bladder Function

- ☐ Irritability
- ☐ Headaches
- ☐ Easy to anger
- ☐ Migraine
- ☐ Depression
- ☐ Pain in ribcage
- ☐ Gall stones
- ☐ Muscle cramps/spasms
- ☐ Manic moods
- ☐ Easily stressed
- ☐ Chronic neck or shoulder tension
- ☐ Insomnia
- ☐ Seizures
- ☐ Acne/Rashes

Eyes – Liver Function

- ☐ Itchy eyes
- ☐ Grittiness
- ☐ Bloodshot
- ☐ Far sighted
- ☐ Dry eyes
- ☐ Poor night vision
- ☐ Seeing spots
- ☐ Astigmatism
- ☐ Watery eyes
- ☐ Red and irritated
- ☐ Near sighted
- ☐ Glaucoma

Kidney and Urinary Bladder Function

- ☐ Frequent cavities
- ☐ Weak knees
- ☐ Cold lower back
- ☐ Incontinence
- ☐ Broken/loose teeth
- ☐ Knee soreness
- ☐ Cold hips/buttocks
- ☐ Hair loss
- ☐ Weak bones
- ☐ Low back pain
- ☐ Cold knees
- ☐ Early graying of hair
- ☐ Hearing loss
- ☐ Quick to fear/fright
- ☐ Ringing in ears

Urinary Function

- ☐ Cloudy
- ☐ Reddish color
- ☐ Small amount
- ☐ Night-time urination
- ☐ Dark Yellow
- ☐ Large amount
- ☐ Strong odor
- ☐ Difficulty initiating urination
- ☐ Clear color
- ☐ Dribbling
- ☐ Very frequent
- ☐ Pain or burning

Libido Function

- ☐ Normal
- ☐ High sex drive
- ☐ Diminished sex drive

Male

- ☐ Prostate Problems
- ☐ Painful/swollen testicles
- ☐ Ejaculation problems
- ☐ Discharge
- ☐ Impotence
- ☐ Infertility
- ☐ Difficulty getting or maintaining an erection

Female

- ☐ Pelvic infection
- ☐ Endometriosis
- ☐ Vaginal discharge
- ☐ Frequent vaginal infections
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Irregular periods
- ☐ Clots
- ☐ Breast tenderness
- ☐ Breast lumps
- ☐ Fertility problems
- ☐ Hot flashes
- ☐ Moodiness related to periods

_____ number of pregnancies _____ number of births _____ miscarriages _____ abortions

_____ premature births _____ cesareans _____ difficult delivery

Is there any possibility that you are pregnant? Y ☐ N ☐

First date of last period _______________ Age of first menses _____

Duration of periods _____ days, cycle _____ days. Do you practice birth control? Y ☐ N ☐

If yes, what type and for how long? _________________________________

Home/Work Environment

Do you work or live in an environment with:

- ☐ New carpet/new paint (within 1-2 years)
- ☐ Construction (onsite or nearby)
- ☐ Near a power plant
- ☐ Dogs or Cats
- ☐ Strong fumes/chemical odors
- ☐ Strong cleaning products
- ☐ Perfumes/air fresheners/scented candles
- ☐ No windows/no outdoor ventilation
- ☐ Second-hand smoke
- ☐ Old building/house
- ☐ Ionizing air purifier(s)

Do you use household cleaning products, disinfectants, paint, paint strippers, varnish remover, cosmetics or chemicals in your work/on a daily basis? Y ☐ N ☐ Please Describe. _________________________________