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PATIENT INTAKE FORM

Name: _____Date_____
(First) (Middle) (Last)
Street Address _____
City _____ State _____Zip Code_____
Home Telephone _____ Work_____
E-Mail_____
Age:_____Date of Birth _____ Female:_____Male_____
Marital Status _____ Occupation_____
Emergency Contact _____ Telephone _____
Relationship of this person to you _____
Referred By_____ How did you hear about us _____
Family Physician _____ _____
Insurance Carrier_____ Policy Number _____
Have you tried Acupuncture or Chinese Herbal Medicine before? _____
Results_____

HEALTH HISTORY QUESTIONAIRE

What is your primary concern, condition, injury or illness?_____
How long has it bothered you? _____
Describe what caused it or how it started_____
_____
_____
_____
How does this condition affect work, sleep, appetite, etc.? _____
_____
_____
_____
Have you received treatment for this condition?_ When? _____
From whom? _____
What was the diagnosis?_____
What were the results of the treatment? _____
Has the condition gotten: Better_____ Worse_____Same_____

SYSTEMS REVIEW

Please circle: Code P = previous condition Y = present condition N = never had

Depression	Y P N	Anxiety or nervousness	Y P N
Easily stressed	Y P N	Diabetes	Y P N
Fatigue	Y P N	Seizure	Y P N
Numbness or tingling	Y P N	Rashes	Y P N
Acne/Boils	Y P N	Itching	Y P N
Headaches	Y P N	Migraines	Y P N
Jaw/TMJ	Y P N	Floaters in eyes	Y P N
Glasses/contacts	Y P N	Blurriness	Y P N
Tearing/dryness	Y P N	Glaucoma	Y P N
Impaired hearing	Y P N	Ringing in ears	Y P N
Cough	Y P N	Phlegm	Y P N
Asthma	Y P N	Bronchitis	Y P N
Shortness of breath	Y P N	Difficulty breathing	Y P N
Chest pain	Y P N	Palpitations/Flutters	Y P N
Heart Disease	Y P N	Swelling in ankles	Y P N
High/Low Blood Pressure	Y P N	Fainting	Y P N
Heartburn	Y P N	Nausea/Vomiting	Y P N
Constipation	Y P N	Diarrhea	Y P N
Blood in stool	Y P N	Gall bladder disease	Y P N
Pain in urination	Y P N	Urinary frequency	Y P N
Frequency at night	Y P N	Inability to hold urine	Y P N
Frequent infections	Y P N	Kidney stone	Y P N
Sleep soundly	Y P N	Dream excessively	Y P N
Wake in the night	Y P N	Trouble returning to sleep	Y P N
Trouble falling asleep	Y P N		
Physically or mentally restless	Y P N	Wake too early	Y P N
Arthritis	Y P N	Joint pain/stiffness	Y P N
Easy bruising or bleeding	Y P N	Muscle spasms/stiffness	Y P N
Varicose veins	Y P N	Anemia	Y P N
Weakness	Y P N		

FEMALE REPRODUCTION

Age of first menses_____		Are cycles regular	Y P N
Length of cycle_____days		Difficulty conceiving	Y P N
Duration of cycle_____days		Abnormal PAP	Y P N
Painful menses	Y P N	Clotting	Y P N
Heavy or excess flow	Y P N	Discharge	Y P N
PMS	Y P N	Birth control	Y P N
Endometriosis	Y P N	Ovarian cysts	Y P N
Breast tenderness/pain	Y P N	Spotting	Y P N

MALE REPRODUCTION

Hernia	Y P N	Testicular masses/pain	Y P N
Impotence	Y P N	Prostate Disease	Y P N

HEALTH HISTORY

From whom are you currently receiving health care? _____
What is your chief complaint? _____
What, if any, contagious diseases do you have at this time? _____
What childhood illnesses have you had? _____
What hospitalizations have you had? _____
What allergies to drugs or foods do you have? _____
What current medications do you take? _____

FAMILY HISTORY

	Father	Møther	Brothers	Sisters	Spouse	Child(ren)
Age (if living)	____	_____	_____	____	_____	_____
Health (G or P	___	_____	_____	____	_____	_____
List any chronic conditions in your family	_	_____	_____			

LIFESTYLE

Do you exercise? Y N If yes, what kind? _____
How do you describe your body temperature?(circle one) Cool, cold, neutral, warm, hot
In what part of your body do you hold your tension? _____
Do you take vitamins or other supplements? _____
If there is any additional information you would llke to add, use the back of this sheet.

ACUPUNCTURE CONSENT FORM

Acupuncture is performed by the insertion of needles through the skin, and/or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat pain, disease, or other dysfunctions. Adverse side effects may result. These could include, but are not limited to local bruising, minor bleeding, fainting , temporary pain or discomfort, and temporary aggravation of symptoms existing prior to acupuncture treatment.
Acupuncturists may recommend treatment with substances from the Oriental Material Medica. Adverse side effects may result from taking these substances. These include, but are not limited to , changes in bowel habits, temporary abdominal pain or discomfort , and the possible temporary aggravation of symptoms existing prior to herbal treatment.
If you experience any problems which you can associate with these substances, stop taking them and call your practitioner

Signature_____