Acupuncture Clinic Intake Form

Name Last-_____First_____SSN #_____ / _____ /_____

Date of Birth_____ /_____ /_____ Gender F ____M ____ Email _____

Address _____City _____State_____Zip Code_____

Telephone: Home (_____)_____-_____ Work (_____) _____-_____Ext._____

Marital Status: _____Education (Highest grade or degree achieved)_____

Option: Height _____ Weight _____ HIV _____ HbsAg _____

How did you hear about our clinic?_____

Have you been treated by Acupuncture or Oriental medicine before? _____

Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

_____ _____ / _____ / _____

Patient's signature (Parent or Guardian if under 18) **Date**

In an Emergency Notify Name_____ Relationship to client_____

Phone (Day) (_____)_____-_____(Evening) (_____)_____-_____

1. Main problem you would like us to help you with: _____
2. How long ago did this problem begin? _____
3. Have you been given a diagnosis for this problem? If so, what? _____
4. What kinds of treatment have you tried? _____
5. Are you currently receiving treatment for your problem? _____If so, please describe:_____
6. Does anything improve your problem? _____

PAST MEDICAL HISTORY

Illnesses: _____

_____

Surgeries_____

_____

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

Do you have, or have you ever had, any **Infectious Diseases**? Yes ☐ No ☐

If so, please describe _____

Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

_____

_____

Allergies:

_____

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side _____
Father's Side _____
Siblings _____
If any of the above is deceased, what was the cause? _____

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) _____
Childhood health _____
Location of upbringing (Geographically prone to certain diseases, habits, etc.) _____
Current Emotional Health _____
Current Quality of Life _____
Current Relationship/Quality _____
Current Predominant Emotiom _____
Occupation _____ Stress Level _____
Have you had any unusual stresses recently? _____
Favorite time of year (body type) _____ Worst _____
Hobbies & Recreational Habits _____
Do you have a regular exercise program? Yes ☐ No ☐ If so, please describe: _____
Have you traveled abroad in the past year? Yes ☐ No ☐ Where? _____
If applicable, please describe smoking or alcohol intake : _____

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Areas of Numbness	☐ Anxiety
☐ Concussion	☐ Lack of Coordination	☐ Poor Memory
☐ Dizziness	☐ Loss of Balance	☐ Easily Angered
☐ Headaches	☐ Fainting	☐ Depression
☐ Migraines	☐ Disorientation	☐ Mania
☐ Easily Susceptible to Stress		

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____
Any nervous habits? _____

PREGNANCY & GYNECOLOGY

___Age at First Menses	___ Number of Pregnancies	☐ Birth Control?
___Period between Menses	___ Number of Births	What type? _____
___Duration of Menses	___ Miscarriages	How long? _____
☐ Unusual Character	___Abortions	☐ Fertility Problems
☐ Heavy or ☐ Light	☐ Difficult Births	☐ Vaginal Discharge
☐ Irregular Periods	☐ Painful Periods	☐ Vaginal Sores
☐ Breast Lumps	☐ Clots	

First Date of Last Menstrual Cycle _____/_____/_____ Date of Last Pap Smear _____/_____/_____
Do you experience changes in Body and/or Psyche prior to menstruation ? _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Fatigue
- ☐ Tremors
- ☐ Seizures
- ☐ Night Sweats
- ☐ Change in Appetite
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drops?

What time of Day? _____

- ☐ Poor Sleep/ Insomnia
- ☐ Dream Disturbed Sleep
- ☐ Depression
- ☐ Mania
- ☐ Emotional Changes
- ☐ Day Sweating
- ☐ Poor Balance
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Poor Appetite
- ☐ Strong thirst for Hot or Cold drinks?
- ☐ Headaches
- ☐ Localized Weakness
- ☐ Bleeding or Bruising
- ☐ Joint Pain

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold Sweats
- ☐ Swelling of Feet
- ☐ Swelling of Hands
- ☐ Difficulty in Breathing
- ☐ Cold Hands/Feet
- ☐ Phlebitis
- ☐ Blood Clots
- ☐ Palpitations

RESPIRATORY

- ☐ Cough
- ☐ Asthma
- ☐ Easily Winded w/ Exertion when laying down
- ☐ Production of phlegm
- ☐ Pain w/ Deep Breaths
- ☐ Bronchitis
- ☐ Difficulty in Breathing
- ☐ Shortness of Breath
- ☐ Coughing Blood

What Color? _____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Ulcers
- ☐ Hernia
- ☐ Abdominal Pain/ Cramps
- ☐ Parasites
- ☐ Belching
- ☐ Bad Breath
- ☐ Hemorrhoids
- ☐ Digestive Disorders
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stools

GENITO-URINARY

- ☐ Pain on Urination
- ☐ Urgent Urination
- ☐ Frequent Urination
- ☐ Unable to Hold Urine
- ☐ Decrease in Urine
- ☐ Blood in Urine
- ☐ Impotency/ Infertility
- ☐ Genital Sores
- ☐ Kidney sores
- ☐ Waking up to Urinate

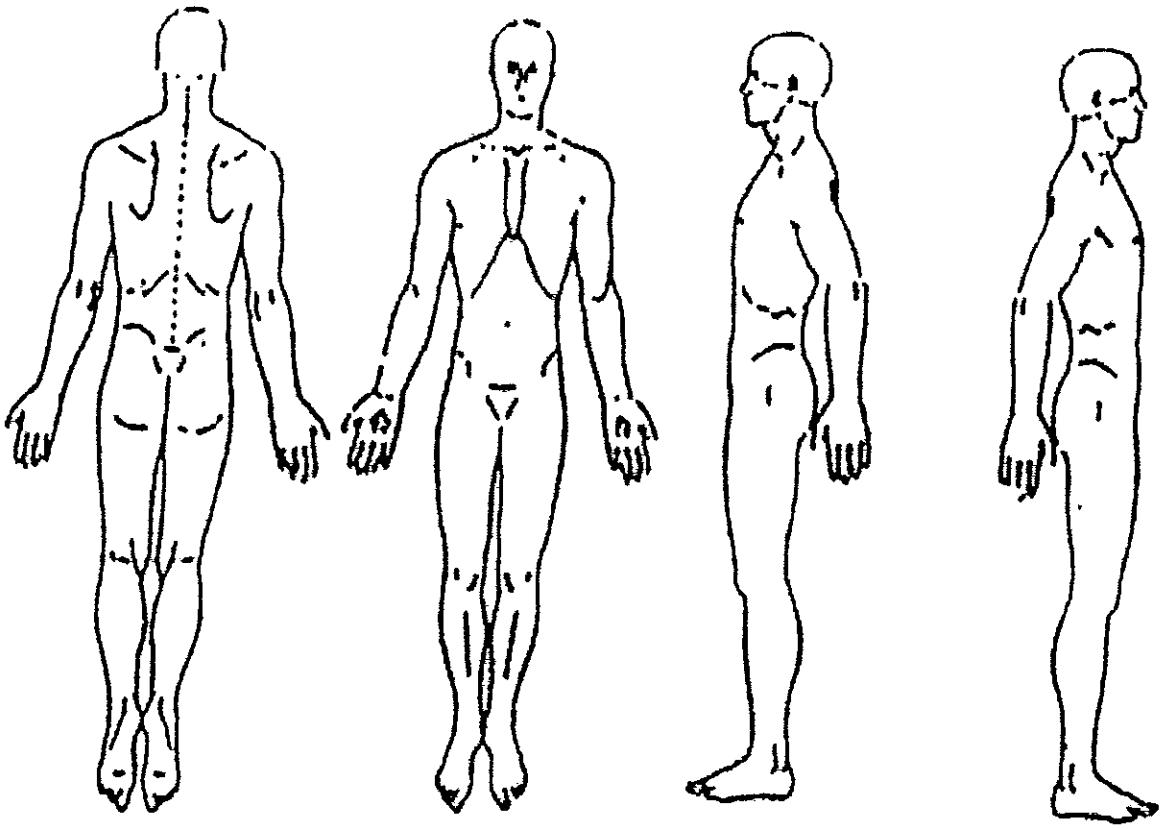
How often? _____

MUSCULOSKELETAL

- ☐ Muscular Weakness
- ☐ Muscle Cramps
- ☐ Injuries or Falls
- ☐ General Aches
- ☐ Arthritis
- ☐ Spasms
- ☐ Muscular Atrophy
- ☐ Joint Instability
- ☐ Recent Sprains

Please circle on the diagram any areas of any type of pain or injury.

Please try to describe the type and quality of the pain _____



Are there any other internal organ or systemic dysfunctions that we should be aware of? _____

_____

Are there any other problems you would like to discuss? _____

_____