

Initial Intake Form

On the following pages you will find a very detailed questionnaire. Please answer these questions as thoughtfully as possible as the information you provide about your lifestyle, habits, and health history will allow me to determine the best treatment approach for you. Chinese medicine is a holistic medicine that tailors each treatment to the individual and many of these questions may appear to be unrelated to your condition, but will provide useful information. All of the information in this questionnaire is STRICTLY CONFIDENTIAL by law. Thank you and I look forward to working with you.

Personal Information

Name _____ Date _____

Address _____

City _____ State _____ Zip code _____

Phone (*contact #*) _____ (*work*) _____

E-mail _____ Age _____ Date of Birth _____

Occupation _____ Name of Employer/School _____

Can I add you to my email list in order to share updates, information and wellness tips? Yes No

Gender : Male Female

Relationships: Married Partnership Single Separated Divorced Widowed

Live with: Spouse Partnership Children Friends Alone

Emergency Contact: _____ Relationship: _____

Address: _____

Phone (*contact #*) _____ (*work*) _____

How did you hear about our clinic? _____

Insurance Information

Do you have insurance that covers acupuncture? Yes No Unsure

Insurance Company: _____

Subscriber: _____ Phone: _____

Policy/Group# _____ Identification # _____

Health History Questionnaire

Name/DOB: _____

Are you currently receiving healthcare? Yes No

If yes, where and from whom? _____

What are you most important health concerns that you are seeking treatment for?

List as many as you can in order of importance

Any major illnesses in childhood or adulthood? If so, what? _____

Any significant scars on your body? If so, please list the location(s) _____

Family History

Are there any health conditions that are known to run in your family? If so, what? _____

Hospitalizations and Surgery

What hospitalizations and/or surgeries have you had? Any organs removed?

Reason: _____ Year : _____

Reason: _____ Year : _____

X-Rays and Special Studies

X-rays, CAT scans, MRI's or other studies you have had: _____

ALLERGIES: Are you now allergic or hypersensitive to any foods, drugs or medications, environmental, chemicals or animals? Yes No

If yes, please describe: _____

PACEMAKER: Do you now have an artificial pacemaker? (a medical device to regulate heart beat) Yes No

CHRONIC DISEASES: Do you now have any chronic (or long term) diseases? Yes No

If yes, please describe: _____

CONTAGIOUS DISEASES: Do you now have any contagious (or infectious) diseases? Yes No

If yes, please describe: _____

BLEEDING DISORDERS: Do you now have any kind of bleeding disorder? Yes No

If yes, please describe: _____

FEMALE PATIENTS ONLY: Are you pregnant, or could you potentially be pregnant? Yes No

If yes, please describe: _____

Current Medications

Please list any prescription medications, over the counter medications, vitamins, or other supplements or herbs you are currently taking (*please list amount, frequency and duration*):

Name/DOB: _____

Height: _____ Weight: _____ How long have you been at this weight? _____

Does it fluctuate much? _____ Do you take any weight loss products? _____

How would you describe your health as a child? _____

How would you describe your health now? _____

Predominant emotion: Happy/joyful Sad/Depressed Easily angered/irritable Fearful Anxious/Nervous
Other: _____

Are you receiving therapy for emotional work? Yes No Past

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list any foods that make you feel bad/aggravate your symptoms: _____

Habits

Drink coffee? Other caffeine? Yes No Past
How much/often? _____

Drink alcoholic beverages: Yes No Past
How much/often? _____

Use tobacco? Yes No Past
How much/often? _____

Use recreational drugs? Yes No Past
How much/often? _____

Do you have a history of abuse? Yes No

Any major traumas? Yes No

Do you exercise? Yes No

If yes, what kind? _____ How often? _____

How do you feel after exercise? energized fatigued Other? _____

Do you sleep well? Yes No Number of hours? _____ Do you wake rested? Yes No

Do you have vivid or disturbing dreams? Yes No

What are your main interests and hobbies: _____

Do you eat three meals a day? Yes No

Do you add salt to your food? Yes No

Do you enjoy your work? Yes No

Are you under a lot of stress? Yes No

Have a supportive relationship? Yes No

Have a spiritual or religious practice? Yes No

Take vacations? Yes No

Review of Systems

Name/DOB:

Y = current condition; N = never; P = past condition

Dry or red eyes Y N P

Blurred or unclear vision Y N P

Floater or spots in vision Y N P

Headaches Y N P

Migraines Y N P

TMD / jaw problems Y N P

Muscle spasms or twitching Y N P

Tension in shoulder or neck Y N P

Pain under ribs or diaphragm Y N P

Chest pain or stuffiness Y N P

Difficult swallowing, laryngitis Y N P

Irritable or short tempered Y N P

Herpes Y N P

Ulcers Y N P

Frequent sighing Y N P

Skin rashes Y N P

Poor appetite Y N P

Fatigue after eating Y N P

Abdominal bloating Y N P

General feeling of body heaviness Y N P

Swollen hands or feet Y N P

Prolapsed organs, hemorrhoids Y N P

Bruise easily Y N P

Hard to gain, lose, regulate weight Y N P

Heartburn or acid reflux Y N P

Peculiar taste Y N P

Stomach or abdominal pain Y N P

Frequent belching Y N P

Frequent abdominal gas Y N P

Indigestion, nausea or vomiting Y N P

Excessive hunger Y N P

Excessive thirst Y N P

Bleeding, swollen, painful gums Y N P

Bad breath Y N P

Easily worried, overwhelmed Y N P

Mental sluggishness Y N P

Fatigue, tiredness, generally weak Y N P

Sweat easily, spontaneously Y N P

Sweat at night Y N P

Feverish in afternoon Y N P

Facial flushes Y N P

Dizziness or vertigo Y N P

Feel better with exercise Y N P

Feel worse with exercise Y N P

Body feels colder Y N P

Body feels warmer Y N P

Numbness Y N P

Frequent colds or flu Y N P

Colds or flu linger for weeks/months Y N P

Dry skin, nose, mouth, or throat Y N P

Asthma/Bronchitis/Allergies Y N P

Cough Y N P

Acne, rashes, eczema Y N P

Shortness of breath with little exertion Y N P

Nasal discharge, congestion Y N P

Nose bleeds Y N P

Frequent sore throats Y N P

Sadness/Grief Y N P

Low back pain Y N P

Sore, weak or cold knees Y N P

Puffy or darkness under eyes Y N P

ringing in ears or poor hearing Y N P

Low motivation/lack of willpower Y N P

Wake more than one time a night to Urinate Y N P

Puffy or swollen ankles or feet Y N P

Review of Systems Continued

Y = current condition; N = never; P = past condition

Insomnia Y N P

Mouth or tongue sores Y N P

Chest pain Y N P

Poor memory Y N P

Anxiety or nervousness Y N P

Mental confusion or disorientation Y N P

Blood or mucous in stools Y N P

Pain with elimination Y N P

Constipation Y N P

Constipation alternating with diarrhea Y N P

Irritable bowel syndrome Y N P

Undigested food in stools Y N P

Loose stools or diarrhea Y N P

Dry, hard stools Y N P

Difficulty passing stool Y N P

Urgency with urination Y N P

Difficulty urinating Y N P

Painful urination Y N P

Strong smelling urine Y N P

Blood in urine Y N P

Excessive urination Y N P

Frequent urination Y N P

Dribbling or incontinence of urine Y N P

Women Only

Age at first menses _____

Age at last menses (if applicable) _____

Length of cycle _____

Duration of menses (days) _____

Pregnancies _____

Live births _____

Miscarriages _____

Abortions _____

Date of Last Pap _____

Abnormalities _____

Are you cycles regular Y N P

Large Clots Y N P

PMS Y N P

Endometriosis Y N P

Uterine Fibroids Y N P

Ovarian Cysts Y N P

Difficulty conceiving Y N P

Vaginal Discharge/infections Y N P

Interstitial Cystitis Y N P

On birth control or hormones Y N P

Menopausal symptoms Y N P

Date of last period _____

Flow is: light medium heavy inconsistent

Color is: brown bright red brick red red-purple pale red watery thick

Libido is: low medium high

Men Only

Hernias Y N P

Testicular Pain Y N P

Lump or swelling in testicles Y N P

Difficult or loss of erection Y N P

Nocturnal emissions Y N P

Prostate disease Y N P

Infertility Y N P

Other _____

Libido is: low medium high

Thank You! I appreciate the time you spent to complete this.

Musculoskeletal

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.

KEY

XXX Spasm

ZZZ Tenderness

//// Stabbing

⊗⊗ Numbness/Tingling

000 Ache/Pain

↓ or ↑ Radiating Pain

Please make a slash through this line to indicate your level of pain

