

## 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

Sex Assigned at Birth:  Male  Female I Identify My Gender As: \_\_\_\_\_

Preferred Pronoun:  He  She  They  Ze  No Preference  None listed: \_\_\_\_\_

Relationships:  Married  Partnership  Single  Separated  Divorced  Widowed  \_\_\_\_\_

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 Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Identification # \_\_\_\_\_

# Health History Questionnaire

Name/DOB: \_\_\_\_\_

Are you currently receiving healthcare?  Yes  No

If yes, Dr's name and clinic and any diagnoses? \_\_\_\_\_

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

*List in order of importance*

\_\_\_\_\_  
\_\_\_\_\_

Any major illnesses in childhood or adulthood ?  Yes  No If yes, what? \_\_\_\_\_

Any problems during your birth?  Yes  No If yes, what? \_\_\_\_\_

Vaccines: any reactions you remember?  Yes  No If yes, what? \_\_\_\_\_

Were you breast fed as a baby?  Yes  No If know, how long? \_\_\_\_\_

Long term antibiotic or steroid use?  Yes  No

Any scars on your body (including small ones)?  Yes  No If yes, where? \_\_\_\_\_

Ever since \_\_\_\_\_ happened, nothing has been the same.

## Family History

Please note all major illnesses in your immediate family, like diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, cancer, blood disorders, etc. \_\_\_\_\_

\_\_\_\_\_

## Hospitalizations, Surgeries, Imaging

What hospitalizations and/or surgeries or MRI's, X-rays or Imagining have you had?

Reason: \_\_\_\_\_ Year : \_\_\_\_\_

Reason: \_\_\_\_\_ Year : \_\_\_\_\_

Reason: \_\_\_\_\_ Year : \_\_\_\_\_

**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 many ounces in day? \_\_\_\_\_

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 drink water?  Yes  No  Past

How many ounces in a day? \_\_\_\_\_

Do you have a history of abuse?  Yes  No

Any major traumas?  Yes  No

Do you exercise?  Yes  No

If yes, what kind? \_\_\_\_\_

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

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: \_\_\_\_\_

# Review of Systems

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

Name/DOB: \_\_\_\_\_

- 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

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- 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

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- 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

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- 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

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- 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

Name/DOB: \_\_\_\_\_

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 your cycles regular  Y  N  P
- Clots  Y  N  P
- PMS  Y  N  P
- Cramps  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.

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

# 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**

