Green Lotus
acupuncture clinic

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: _____

Sex Assigned at Birth: ❒ Male ❒ Female I Identify My Gender As: _____

My Pronouns Are: _____

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 #: _____

Name: _____ **Date of Birth:** _____

Health History Questionnaire

What are the most important health concerns that you are seeking treatment for? *List in order of importance*

_____

_____

_____

Any Medical Diagnoses: _____

Any major illnesses in childhood or adulthood? ❒ Yes ❒ No If yes, what? _____

Any problems during your birth? ❒ Yes ❒ No If yes, what? _____

Any long term antibiotic, steroid, NSAID 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, such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, cancer, blood disorders, etc.:

_____

_____

_____

Hospitalizations, Surgeries, Imaging

Please list any previous hospitalizations, surgeries, MRI's, X-rays or additional imaging have you had.

Reason: _____ Year: _____

Reason: _____ Year: _____

Reason: _____ Year: _____

Reason: _____ Year: _____

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

If yes, please describe: _____

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

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

If yes, please describe: _____

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

If yes, please describe: _____

BLEEDING DISORDERS: Do you currently have any kind of bleeding disorders? ❒ Yes ❒ No

If yes, please describe: _____

PREGNANCY: Are you pregnant, or could you potentially be pregnant? ❒ Yes ❒ No ❒ Not Applicable

If yes, please describe: _____

Name: _____ **Date of Birth:** _____

Current Medications

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

_____

_____

_____

Last known height:_____ Last known weight:_____

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 How many ounces in a day? _____

Are you under a lot of stress? ❒ 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

Name: **Date of Birth:**

Review of Systems

***Y** = current condition; **P** = past condition*

Dry or red eyes	❒ Y	❒ P
Blurred or unclear vision	❒ Y	❒ P
Floaters or spots in vision	❒ Y	❒ P
Headaches	❒ Y	❒ P
Migraines	❒ Y	❒ P
TMD / jaw problems	❒ Y	❒ P
Muscle spasms or twitching	❒ Y	❒ P
Tension in shoulder or neck	❒ Y	❒ P
Pain under ribs or diaphragm	❒ Y	❒ P
Chest pain or stuffiness	❒ Y	❒ P
Difficult swallowing, laryngitis	❒ Y	❒ P
Irritable or short tempered	❒ Y	❒ P
Herpes	❒ Y	❒ P
Frequent sighing	❒ Y	❒ P
Skin rashes	❒ Y	❒ P
Poor appetite	❒ Y	❒ P
Fatigue after eating	❒ Y	❒ P
Abdominal bloating	❒ Y	❒ P
General feeling of body heaviness	❒ Y	❒ P
Swollen hands or feet	❒ Y	❒ P
Prolapsed organs, hemorrhoids	❒ Y	❒ P
Bruise easily	❒ Y	❒ P
Hard to gain, lose, regulate weight	❒ Y	❒ P
Heartburn or acid reflux	❒ Y	❒ P
Peculiar taste	❒ Y	❒ P
Stomach or abdominal pain	❒ Y	❒ P
Frequent belching	❒ Y	❒ P
Frequent abdominal gas	❒ Y	❒ P
Indigestion, nausea or vomiting	❒ Y	❒ P
Excessive hunger	❒ Y	❒ P
Excessive thirst	❒ Y	❒ P
Bleeding, swollen, painful gums	❒ Y	❒ P
Bad breath	❒ Y	❒ P
Easily worried, overwhelmed	❒ Y	❒ P
Mental sluggishness	❒ Y	❒ P
Fatigue, tiredness, generally weak	❒ Y	❒ P
Sweat easily, spontaneously	❒ Y	❒ P
Sweat at night	❒ Y	❒ P
Facial flushes	❒ Y	❒ P
Dizziness or vertigo	❒ Y	❒ P
Feel better with exercise	❒ Y	❒ P
Feel worse with exercise	❒ Y	❒ P
Body feels colder	❒ Y	❒ P
Body feels warmer	❒ Y	❒ P
Numbness	❒ Y	❒ P
Frequent colds or flu	❒ Y	❒ P
Colds or flu linger for weeks/months	❒ Y	❒ P
Dry skin, nose, mouth, or throat	❒ Y	❒ P
Asthma/Bronchitis/Allergies	❒ Y	❒ P
Cough	❒ Y	❒ P
Acne, rashes, eczema	❒ Y	❒ P
Shortness of breath with little exertion	❒ Y	❒ P
Nasal discharge, congestion	❒ Y	❒ P
Frequent sore throats	❒ Y	❒ P
Sadness/Grief	❒ Y	❒ P
Low back pain	❒ Y	❒ P
Sore, weak or cold knees	❒ Y	❒ P
Puffy or darkness under eyes	❒ Y	❒ P
Ringing in ears or poor hearing	❒ Y	❒ P
Low motivation/lack of willpower	❒ Y	❒ P
Wake more than one time a night to urinate	❒ Y	❒ P
Puffy or swollen ankles or feet	❒ Y	❒ P

Name: _____ **Date of Birth:** _____

Review of Systems Continued

***Y** = current condition; **P** = past condition*

Insomnia	❒ Y	❒ P
Mouth or tongue sores	❒ Y	❒ P
Chest pain	❒ Y	❒ P
Poor memory	❒ Y	❒ P
Anxiety or nervousness	❒ Y	❒ P
Mental confusion or disorientation	❒ Y	❒ P
Blood or mucous in stools	❒ Y	❒ P
Pain with elimination	❒ Y	❒ P
Constipation	❒ Y	❒ P
Constipation alternating with diarrhea	❒ Y	❒ P
Irritable bowel syndrome	❒ Y	❒ P
Undigested food in stools	❒ Y	❒ P
Loose stools or diarrhea	❒ Y	❒ P
Dry, hard stools	❒ Y	❒ P
Difficulty passing stool	❒ Y	❒ P
Urgency with urination	❒ Y	❒ P
Difficulty urinating	❒ Y	❒ P
Painful urination	❒ Y	❒ P
Strong smelling urine	❒ Y	❒ P
Blood in urine	❒ Y	❒ P
Excessive urination	❒ Y	❒ P
Frequent urination	❒ Y	❒ P
Dribbling or incontinence of urine	❒ Y	❒ P

Female Reproductive Anatomy

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	❒ P
Clots	❒ Y	❒ P
PMS	❒ Y	❒ P
Cramps	❒ Y	❒ P
Endometriosis	❒ Y	❒ P
Uterine fibroids	❒ Y	❒ P
Ovarian cysts	❒ Y	❒ P
Difficulty conceiving	❒ Y	❒ P
Vaginal discharge/infections	❒ Y	❒ P
Interstitial cystitis	❒ Y	❒ P
On birth control or hormones	❒ Y	❒ P
Menopausal symptoms	❒ Y	❒ P

Date of last period: _____

Flow is: ❒ light ❒ medium ❒ heavy ❒ inconsistent

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

Male Reproductive Anatomy

Hernias	❒ Y	❒ P
Lump or swelling in testicles	❒ Y	❒ P
Difficult or loss of erection	❒ Y	❒ P
Prostate disease	❒ Y	❒ P
Infertility	❒ Y	❒ P

Other: _____

_____

Patient Signature **Date**
(or guardian if patient is a minor)