

Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION:

Name: _____ Sex: F M Date: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ (Home) _____ (Work) _____ (Mobile)

Date of Birth: _____ Age: _____ Social Security No: _____

Single: Married: Separated: Divorced: Widowed: Partnered:

Education: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Telephone: _____ (Home) _____ (Mobile)

Name of Physician*: _____ Physician's Telephone: _____

Physician's Address: _____

Date of Last Physician Appointment: _____ Date of Last Gynecology Exam: _____ N/A

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? Yes No

*No contact will be made to the physician without your permission.

FAMILY HISTORY — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box(es).

	Self (date)	Mother	Father	Sibling	Spouse	Children
Cancer or Tumors						
Diabetes						
Blood or Bleeding Disorders/Anemia						
Seizures						
High Blood Pressure/Heart Disease						
Allergies						
Stroke						
Drug Abuse						
Depression or Mental Illness						
Deceased (age)						
Hepatitis						
Kidney Disorders						
Thyroid Disorders						
Musculo-Skeletal Disorder						
Blood Transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Patient Intake Form

MEDICAL: If you have ever been hospitalized for a serious medical illness or operation, please write the most recent ones below. (Do not include normal pregnancies.)

YEAR	OPERATION / ILLNESS

MEDICINES:

What prescription drugs are you currently taking:

For what condition?

What over-the-counter medications, herbs, or supplements are you currently taking:

For what condition?

Please put a "C" if the condition is current or a "P" if you had it in the past.

General

- Insomnia
- Dreams/Nightmares
- Fatigue
- Poor Memory
- Strongly Like Cold Drinks
- Strongly Like Hot Drinks
- Recent Weight Loss/Gain
- Chills
- Fever

Eyes

- Glasses/Contact Lenses
- Blurred Vision
- Poor Night Vision
- Spots or Floaters
- Eye Inflammation
- Double Vision
- Glaucoma
- Cataracts

Skin

- Hives
- Rashes
- Eczema / Psoriasis
- Night Sweating
- Excess Sweating
- Dry Skin
- Easily Bruised
- Changes in Moles, Lumps
- Itching

Head & Neck

- Headaches
- Migraines
- Stiff Neck
- Dizziness
- Fainting
- Swollen Glands

Nose, Throat & Mouth

- Sinus Infection
- Hay Fever/Allergies
- Frequent Sore Throat
- Difficulty Swallowing
- Mouth & Tongue Ulcers
- Frequent Colds
- Nosebleed
- Dry Nose
- Nasal Congestion
- Loss of Voice
- Thirst
- Excessive Phlegm
- TMJ
- Facial Pain
- Gum Problems
- Dry Mouth

Respiratory

- Difficulty Breathing
- Difficulty Breathing w/Reclining
- Wheezing
- Asthma
- Chronic Cough
- Wet Cough
- Dry Cough
- Coughing Up Phlegm
- Coughing Up Blood
- Shortness of Breath
- Tight Chest
- Pneumonia

Ears

- Ringing
- Hearing Loss
- Hearing Aids
- Infections
- Earache
- Vertigo

Male Genital

- Impotence
- Premature Ejaculation
- Nocturnal Emission
- Pain/Itching of Genitalia
- Lumps in Testicles

Patient Intake Form

Cardiovascular

- _____ High Blood Pressure
- _____ Low Blood Pressure
- _____ Chest Pain or Tightness
- _____ Palpitation
- _____ Rapid Heart Beat
- _____ Irregular Heart Beat
- _____ Poor Circulation
- _____ Swollen Ankles
- _____ Phlebitis
- _____ Anemia
- _____ History of Heart Attack

Gastrointestinal

- _____ Nausea
- _____ Indigestion
- _____ Stomach Pain
- _____ Diarrhea
- _____ Constipation
- _____ Poor Appetite
- _____ Excessive Hunger
- _____ Vomiting
- _____ Gas
- _____ Hiccups
- _____ Acid Regurgitation
- _____ Bloating
- _____ Bad Breath
- _____ Laxative Use
- _____ Bloody Stool

Musculoskeletal

- _____ Joint Pain / Disorder
- _____ Sore Muscles
- _____ Weak Muscles
- _____ Difficulty Walking
- _____ Neck / Shoulder Pain
- _____ Upper Back Pain
- _____ Lower Back Pain
- _____ Rib Pain
- _____ Limited Range of Motion
- _____ Other (describe)
- _____
- _____

Neurological

- _____ Seizures
- _____ Tremors
- _____ Numbness or Tingling
- _____ Pain (describe)
- _____

- _____ Paralysis
- _____ Poor Coordination
- _____ Other (describe)
- _____
- _____

Mental / Emotional

- _____ Depression
- _____ Mood Swings
- _____ Irritability
- _____ Difficulty Relaxing
- _____ Loneliness
- _____ Sensitive
- _____ Shy
- _____ Cry Often
- _____ Worry a Lot
- _____ Compulsive Behaviors
- _____ Difficulty Focusing
- _____ Hopeless Outlook
- _____ Suicidal Thoughts
- _____ Lose Temper
- _____ Frustration

Urinary

- _____ Pain on Urination
- _____ Frequent Urination
- _____ Urgent Urination
- _____ Blood in Urine
- _____ Unable to Hold Urine
- _____ Incomplete Urination
- _____ Bedwetting
- _____ Wake to Urinate
- _____ Increased Libido
- _____ Decreased Libido
- _____ Kidney Stones

Gynecology (Women Only)

- _____ Currently Pregnant
- _____ # of Pregnancies
- _____ Miscarriages
- _____ Abortions
- _____ Menopause
- _____ Hormone Replacement Therapy
- _____ Irregular Periods
- _____ Menstrual Cramps
- _____ Excessive Blood Flow
- _____ Menstrual Blood Clots
- _____ Breast Tenderness
- _____ Abnormal Pap Smear
- _____ Vaginal Infections
- _____ Vaginal Pain / Itching
- _____ Uterine Fibroids
- _____ Endometriosis
- _____ Breast Lumps, Cysts

Infection Screening:

(Check Self and/or Partner)

- _____ HIV Risk Self Partner
- _____ TB Self Partner
- _____ Hepatitis Risk Self Partner
- _____ History of Sexually Transmitted Diseases Self Partner
- _____ Gonorrhea Self Partner
- _____ Chlamydia Self Partner
- _____ Syphilis Self Partner
- _____ Genital Warts Self Partner
- _____ Herpes Oral Genital
- Self Partner

Other Information

Referred by: _____

Signature: _____

Date: _____