Acupuncture Therapy Clinic
704-651-9585

Patient Intake Form

Contact Information Today's Date:____/____/_____

Name:_____ Sex: F ☐ M ☐ DOB:__/__/___ Age:____

Street:_____ Email Address:_____

City:_____ State:_____ Zip:_____ Phone Number:_____

Occupation:_____ Employer:_____

Marital Status: M ☐ S ☐ D ☐ W ☐ # of Children:_____ Alternative Phone Number:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Primary Care Physician: _____ Phone:_____

How did you find out about us? Direct Mail ☐ Location or Walk By ☐ Friend/Relative ☐ Website ☐
Periodicals ☐ Yellow Pages ☐ Other ☐ _____ Referred By:_____

Have you had acupuncture before? Y ☐ N ☐ What was your experience? Good ☐ Not Very Good ☐

Allow contact by Phone? Y ☐ N ☐ If yes, please provide phone number(s) below:
Contact Phone Numbers: _____ (Cell) _____ (Home)
_____ (Other, specify_____)
Allow contact by Texts? Y ☐ N ☐ Allow contact by Mail? Y ☐ N ☐ Allow contact by Email? Y ☐ N ☐

What are your health goals? _____

_____

Is your life balanced? Please indicate your level of personal satisfaction in the following areas of your life by choosing a number from 0 to 10 (0 is completely unsatisfied and 10 is completely satisfied):

Physical Health:	0---------2---------3---------4---------5---------6---------7---------8---------9---------10
Mental Health:	0---------2---------3---------4---------5---------6---------7---------8---------9---------10
Family Health:	0---------2---------3---------4---------5---------6---------7---------8---------9---------10
Social Health:	0---------2---------3---------4---------5---------6---------7---------8---------9---------10
Spiritual Health:	0---------2---------3---------4---------5---------6---------7---------8---------9---------10
Social Health:	0---------2---------3---------4---------5---------6---------7---------8---------9---------10
Financial Health:	0---------2---------3---------4---------5---------6---------7---------8---------9---------10
Sexual Health:	0---------2---------3---------4---------5---------6---------7---------8---------9---------10

Major Health Complaint(s)

Please list in order of significance to you and **check which you would like us to focus on today**.

1. ☐_____ 4. ☐_____
2. ☐_____ 5. ☐_____
3. ☐_____ 6. ☐_____

When did the checked problem begin?_____

What are the precipitating factors?_____

Have you been given a diagnosis for this problem? If so, please describe._____

What kind of treatments have you tried?_____

_____

What makes this problem worse?_____ Better?_____

Is there anybody in your family with the same problem?_____

How does the problem interfere with your daily activities? ☐Work ☐Walking ☐Emotional

☐Sleep ☐Bending ☐Social Life ☐Sitting ☐ Laying Down ☐Relationships

☐Standing ☐Stretching ☐Sexuality ☐Other _____

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P	C		P	C		P	C		P	C	
☐	☐	Alcohol/Drug Abuse	☐	☐	Digestive Disorder	☐	☐	Hypertension	☐	☐	Nervous Disorder
☐	☐	Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Jaundice	☐	☐	Pneumonia
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Liver Disease	☐	☐	Thyroid Disorder
☐	☐	Auto Immune	☐	☐	Heavy Bleeding/Hemorrhage				☐	☐	Tuberculosis
☐	☐	Blood Transfusion	☐	☐	Hepatitis	☐	☐	Mental Illness	☐	☐	Vein Condition
☐	☐	Cancer	☐	☐	High Cholesterol	☐	☐	Migraines	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	HIV/Hepatitis	☐	☐	Other:_____			

Known allergies (food, medications, or other):_____

Significant trauma (car accident, sports injuries etc.):

1_____ 5_____ 9_____

2_____ 6_____ 10_____

3_____ 7_____ 11_____

4_____ 8_____ 10_____

Immunizations:_____

_____

_____

_____

_____

Hospitalizations/Surgeries (procedures and dates):

1_____ 5_____ 9_____

2_____ 6_____ 10_____

3_____ 7_____ 11_____

4_____ 8_____ 12_____

Dental Procedures (include any silver fillings/mercury amalgams):_____

_____

_____

Do you have a history of frequent antibiotic use? Please Describe._____

_____

Allergy shots? Currently ☐ In the past ☐ Never ☐

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc):

1_____ 5_____ 9_____

2_____ 6_____ 10_____

3_____ 7_____ 11_____

4_____ 8_____ 12_____

Family Medical History (please specify family member)

☐Alcoholism/Drug Abuse_____ ☐Heart Disease_____

☐Asthma/Allergies_____ ☐Hypertension_____

☐Cancer_____ ☐Miscarriage_____

☐Depression/Mental Illness_____ ☐Osteoporosis_____

☐Diabetes_____ ☐Stroke_____

☐Other_____

Current Health & Lifestyle

Do you smoke? Y ☐ N ☐ If yes, how many per day?_____ For how long?_____

Do you exercise? Y ☐ N ☐ If yes, how many times per week?_____ Please Describe._____

_____

Do you travel frequently? Y ☐ N ☐ Have you traveled overseas to 'developing' countries? Y ☐ N ☐

Do you sit in traffic/commute as a daily routine? Y ☐ N ☐

Height:_____ Weight: Now_____ One year ago_____ Maximum_____@ Year_____

How many hours do you sleep in general?_____ When do you usually go to bed?_____

List 3 things you do currently that support health.

_____

_____

_____

List your 3 favorite vices (eg smoking, social drinking, sweet tooth…) your overall

_____

_____

_____

Overall, do you feel that your lifestyle contributes to or takes away from your health?

_____

Are you planning on any future surgeries or medical procedures? Y ☐ N ☐ If yes, please describe:

1_____ 5_____ 9_____

2_____ 6_____ 10_____

Diet

Soft drinks per day_____ Cups of tea per day_____ Cups of coffee per day_____

Glasses of water per day_____ Alcoholic beverages per week_____

Are you a vegetarian? Y ☐ N ☐ Yes, but not strict ☐ Explain:_____

Please describe your average daily diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Foods you tend to crave:_____

Medications and Supplements

Medications you are currently taking (please include prescription medicines, vitamins, supplements, over the counter drugs, herbal supplements, etc.):

1_____ 9_____ 17_____

2_____ 10_____ 18_____

3_____ 11_____ 19_____

4_____ 12_____ 20_____

5_____ 13_____ 21_____

6_____ 14_____ 22_____

7_____ 15_____ 23_____

8_____ 16_____ 24_____

Profile

Please check any of the following symptoms that **currently** pertain to you.

General

☐Cold hands	☐Hot body temperature	☐Profuse perspiration	☐Chills
☐Cold feet	☐Cold body temperature	☐Lack of perspiration	☐Fever
☐Sweaty hands	☐Afternoon flushing	☐Perspire easily	☐Strong thirst
☐Sweaty feet	☐Hot flashes	☐Night sweating	☐Lower back pain
☐Frequent cavities	☐Hearing loss	☐Weak knees	☐Cold lower back
☐Broken/loose teeth	☐Ringing in ears/tinnitus	☐Knee soreness	☐Cold hips/buttocks
☐Weak bones	☐Early graying of hair	☐Hair loss	☐Cold knees
☐Dizziness	☐Forgetfulness	☐Fainting	☐Weak nails

Emotions

☐Mood swings	☐Anxiety	☐Fits of laughter	☐Fear
☐Sadness	☐Panic attacks	☐Depression	☐Frequent worrying
☐Nervousness	☐Irritability	☐Anger	☐Easily stressed
☐Bipolar	☐Obsessive/Compulsive	☐Mania	

Skin

☐Acne	☐Dry or Flaky Skin	☐Hives	☐Rashes
☐Dandruff	☐Eczema	☐Psoriasis	☐Ulcerations/Boils

Neuro-Muscular

☐Seizures	☐Lack of coordination	☐Tingling in extremities	☐Numbness
☐Paralysis	☐Loss of balance	☐Muscle spasms	

Cardiovascular

☐Heart palpitations	☐Chest Pain/Angina	☐Tongue ulcers	☐Speech impediment
☐Restless dreams	☐Mental restlessness	☐Insomnia	☐Hallucinations

Respiratory

☐Persistent cough	☐Nasal dryness	☐Chest congestion	☐Chest tightness
☐Nosebleeds	☐Chronic allergies	☐Sneezing	☐Difficulty Breathing
☐Sinus congestion	☐Sore throats	☐Wheezing	☐Shortness of breath
☐Frequent colds/flu			

Gastrointestinal

☐Indigestion	☐Low or weak appetite	☐Fatigue following a meal	☐Hypoglycemia
☐Abrupt weight gain	☐Gurgling in intestines	☐Easily fatigued	☐Strong cravings
☐Abrupt weight loss	☐Bruise easily	☐Gas	☐Hemorrhoids
☐Stomach ache	☐Ravenous appetite	☐Stomach ulcer	☐Nausea
☐Acid reflux	☐Bleeding gums	☐Belching	☐Vomiting
☐Bad breath	☐Heartburn	☐Hiccups	☐Mouth ulcers
☐Loose stools	☐Blood in stools	☐Less than 1 BM per day	☐Constipation
☐Mucous in stools	☐Difficulty moving bowels	☐Small, hard, dry stools	☐Diarrhea

Lymphatic System/Accumulated Dampness

☐Swollen hands	☐Mental fogginess	☐Edema in the legs	☐Heavy limbs/head
☐Swollen feet	☐Mental sluggishness	☐Edema in the abdomen	☐Joint stiffness

Liver/Gall Bladder Function

☐Headaches ☐Migraines ☐Pain in ribcage ☐Gall stones ☐Chronic neck or shoulder tension

Eyes

☐Itchy eyes	☐Watery eyes	☐Poor night vision	☐Cataracts
☐Dry eyes	☐Red and irritated eyes	☐Floaters/Seeing spots	☐Glaucoma

☐Blurry vision

Urinary

☐Cloudy ☐Small amount ☐Night-time urination ☐Incontinence
☐Dark yellow ☐Large amount ☐Difficulty initiating urination ☐Strong odor
☐Clear color ☐Dribbling ☐Very frequent ☐Pain or burning
☐Reddish color

Male

☐Prostate Problems ☐Testicular pain/swelling ☐Ejaculation problems
☐Low sex drive ☐Premature ejaculation ☐Erectile dysfunction/impotence
☐Nocturnal emission ☐Infertility ☐Difficulty maintaining an erection
☐Low sperm count ☐Poor sperm motility ☐Irregular sperm morphology
☐Feeling of coldness or numbness of genitalia ☐Discharge

Do you have any bothersome symptoms? Y ☐ N ☐ Describe:_____

Do you get up at night to urinate? Y ☐ N ☐ How often?_____

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

_____

Have you sought medical intervention for these problems? If so, when?_____

_____

What treatment have you tried for these problems and how successful have they been?

_____

Female

☐Pelvic infection ☐Endometriosis ☐Vaginal dryness ☐Frequent vaginal infections
☐Fibroids ☐Ovarian cysts ☐Abnormal pap smear ☐Abnormal vaginal discharge
☐Breast tenderness ☐Breast lumps ☐Spotting between periods ☐Hot flashes
☐Low sex drive ☐Fertility problems ☐Pain during intercourse ☐Night sweats

Do you experience any of the following associated with your period each month?

☐Water retention ☐Migraine/headache ☐Lower back pain ☐Change in bowel movement
☐Mood swings ☐Irritability ☐Abdominal cramps ☐Breast tenderness/swelling
☐Food cravings ☐Acne ☐Heavy bleeding ☐Scanty/light bleeding
☐Clots ☐Other:_____

_____Number of pregnancies _____number of live births _____miscarriages _____abortions

_____Premature births _____difficult delivery _____cesareans

At what age did you get your first period:_____ First day of last menstrual period:_____

Are your menstrual cycles spaced regularly? Y ☐ N ☐ Cycle length:_____ Period length :_____

Are you currently using birth control? Y ☐ N ☐ If yes, what type and for how long?_____

Have you experienced menopause? Y ☐ N ☐ When?_____

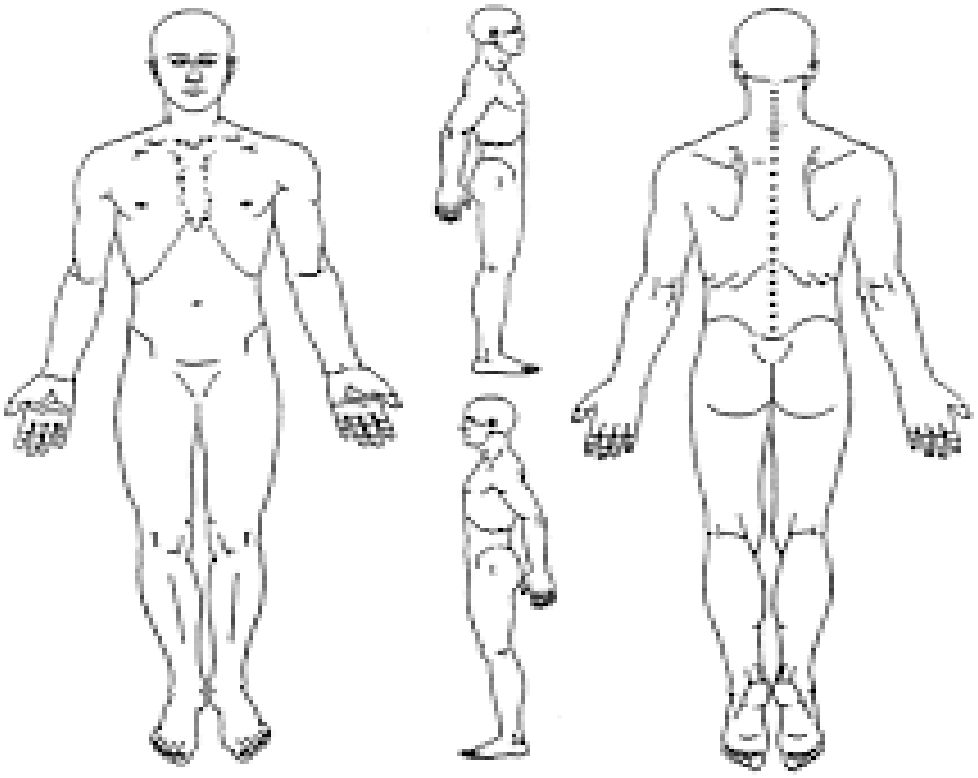
If you are experiencing menopausal symptoms, please describe:_____

_____

_____

Is there <u>any</u> possibility you are pregnant now? Y ☐ N ☐

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:

XXX Sharp / Stabbing
PPP Pins and Needles
DDD Dull / Aching
NNN Numbness

Please rate your **current** level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe

Any other information that could be important for us to know?

Patient Signature Date