PATIENT INFORMATION

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Date_____

Name_____

Address_____

_____
City State Zip

Sex:☐M ☐F Age_____ Birthdate_____

☐Single ☐Married ☐Significant Other
☐Widowed ☐Separated ☐Divorced

Patient SS#_____

Occupation_____

Employer_____

Emp. Address_____

Emp. Phone_____

Spouse/Partner's Name_____

Birthdate_____

Email _____

Add you to our email list and contact you this way?

Yes / No

PHONE NUMBERS

H_____W_____Cell_____

Best time & place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Home phone_____Work phone_____

ACCIDENT INFORMATION

Is condition due to an accident?☐Yes ☐No

Date_____
Type of accident ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?
☐Auto Insurance ☐Employer ☐ Worker Comp. ☐Other

Attorney Name (if applicable)_____

GENERAL INFORMATION

Have you had acupuncture before? ☐Yes ☐No Have you used Chinese herbal medicine? ☐Yes ☐No

Are you currently under the care of a physician? ☐Yes ☐No If Yes, for what?_____

Physician's name:_____ Physician's phone:_____

ORIENTAL MEDICINE INTAKE FORM

Name:_____ **Date:**_____

PRESENT HEALTH CONCERNS: Please list your most important health concerns in order of their significance.

1. _____ Approx. Date of Onset:_____
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other_____

2. _____ Approx. Date of Onset:_____
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other_____

3. _____ Approx. Date of Onset:_____
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other_____

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

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

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

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

Please list **allergies** that you have to any of the following:

Drugs:_____ Foods:_____

Other (i.e. pollen, paint, etc.):_____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

_____

_____

_____

Personal Habits:

☐Tobacco packs/day_____
☐Alcohol drinks/wk_____
☐Coffee/tea/cola cups/day_____
☐Recreational drugs times/wk_____

☐High Stress Level Reason_____

Do you follow any diet regimens/restrictions?
☐Yes ☐No
If Yes, describe:_____

Work Activity:

☐Sitting % of time_____
☐Standing % of time_____
☐Light labor % of time_____
☐Heavy labor % of time_____

Exercise:

Do you exercise regularly? ☐Yes ☐No
If Yes, describe & tell how often:_____

_____

_____

FAMILY INFORMATION

Do you have children? ☐Yes ☐No If Yes, how many?_____Ages_____

Are you, or could you be currently pregnant? ☐Yes ☐No Due date_____

Please check if you have had (in the **last three months**)

GENERAL

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Changes in appetite
- ❑ Weight loss/gain
- ❑ Cravings
- ❑ Peculiar tastes
- ❑ Strong thirst
- ❑ Fevers/Chills
- ❑ Sweat easily
- ❑ Localized weakness
- ❑ Bleed / bruise easily
- ❑ Sudden energy drop (time?)
- ❑ Fatigue
- ❑ Tremors
- ❑ Poor sleeping
- ❑ Heavy sleeping
- ❑ Dream disturbed sleep
- ❑ Night sweats
- ❑ Dizziness

SKIN AND HAIR

- ❑ Rashes/Hives
- ❑ Itching
- ❑ Dry skin
- ❑ Dandruff
- ❑ Ulcerations
- ❑ Eczema/Psoriasis
- ❑ Loss of hair
- ❑ Pimples/Acne
- ❑ Fungal infections
- ❑ Recent moles
- ❑ Change in hair or skin texture

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ Concussions
- ❑ Glasses/Contacts
- ❑ Eye strain/pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Dry eyes
- ❑ Excessive tearing
- ❑ Poor/blurry vision
- ❑ Night blindness
- ❑ Cataracts/Glaucoma
- ❑ Spots in front of eyes
- ❑ Earaches/Infections
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Sinus problems
- ❑ Post nasal drip
- ❑ Excessive phlegm – color_____
- ❑ Nose bleeds
- ❑ Recurrent sore throats
- ❑ Swollen glands
- ❑ Sores on lips/tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Teeth problems
- ❑ Gum problems
- ❑ TMJ disorder
- ❑ Grinding teeth
- ❑ **Headaches** (location, triggers, severity)?

Other head & neck concerns:

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Fainting
- ❑ Cold hands/feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots
- ❑ Phlebitis

Other heart or blood vessel concerns:

RESPIRATORY

- ❑ Cough
- ❑ Coughing blood
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Pain with deep breath
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Production of phlegm - color?_____
  Is it ☐thick or ☐thin

Other lung related concerns:

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Hiccups
- ❑ Belching
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Mucus in stools
- ❑ Acid Regurgitation
- ❑ Abdominal pain
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Hemorrhoids/fissures

History of chronic laxative use?

Other concerns with your general digestion:

GENTIO-URINARY

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Bedwetting
- ❑ Kidney stones
- ❑ Impotency
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Premature ejaculation
- ❑ Nocturnal emissions
- ❑ Sores on genitals
- ❑ Frequent urinary tract infections
- ❑ Chronic yeast infection

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- ❑ Neck pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Hand/wrist pains
- ❑ Muscle pains
- ❑ Muscle weakness
- ❑ Cramps/spasms
- ❑ General joint pain/stiffness
- ❑ Shoulder pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Joint with limited range of motion_____

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

- ❑ Seizures
- ❑ Loss of balance
- ❑ Areas of numbness
- ❑ Tics
- ❑ Lack of coordination
- ❑ Memory loss
- ❑ Concussion
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily susceptible to stress
- ❑ History of emotional/physical abuse

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses_____ If no longer menstruating, approximate date ceased_____

First day of last menses_____ Length between menses:_____days Duration of period:_____days

- ❑ Unusual flow (☐heavy or ☐light)
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Clots in flow
- ❑ Vaginal discharge – color_____
- ❑ Vaginal odor
- ❑ Vaginal dryness
- ❑ Vaginal sores
- ❑ Hot flashes
- ❑ Breast lumps/soreness

GYNECOLOGY (continued)

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP:_____ Results were: normal abnormal unsure
If you use birth control, what type & for how long?

Have you ever used hormonal methods for contraception or period regulation?
(i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

PREGNANCY HISTORY

Number of pregnancies_____ Births_____ Miscarriages_____ Abortions____
Were your births relatively normal? Explain:

Other related concerns:

COMMENTS

Please let us know of any other concerns you would like to address:

Family History: Please fill in the boxes for each condition that applies to one of your family members.

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			

Patient Signature: _____ **Date:** _____

Please mark in the following diagrams where you are currently experiencing your symptoms:
X = Pain
O = Numbness/Tingling
/ = Discomfort