



**Confidential Patient Intake Form**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Given Middle Family

Address: \_\_\_\_\_  
Number Street City State Zip

Telephone Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Gender: M/F/other Single / Married / Separated / Divorced / Lives with: \_\_\_\_\_ Children? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Phone Relationship

Primary Care Physician: \_\_\_\_\_  
Name Address

Doctor's Phone: \_\_\_\_\_ May we confer with your Doctor? Y N Initials: \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_  
Name Phone/Address

Have you had acupuncture before? Y N When? \_\_\_\_\_ Where? \_\_\_\_\_

**What are you here to work on?**

\_\_\_\_\_

**What makes it better or worse?**

\_\_\_\_\_

Have you seen an MD for this? \_\_\_\_\_ When? \_\_\_\_\_

Were you given a **Diagnosis**?

\_\_\_\_\_

Please describe any **major illnesses** or **surgeries** and when they occurred:

\_\_\_\_\_

Please list all known Allergies :

\_\_\_\_\_

Please list all medications and supplements are you taking, use the back if you need more space:

Medication/Supplement Name	Reason Taking / Diagnosis	How Long	Dose & Frequency	Last Dose

**Exercise:** Low      OK      Active  
**Food cravings:** Flavor      Cold      Warm  
**Sleep:** Well / Not Good: \_\_\_\_\_  
**Emotion:**  
**Bowel Movement:**  
**Energy level:** Low      OK      Good

Tobacco:  
 Alcohol:  
 Caffeine:  
 Recreational drugs:

**Work:**  
 Occupation:  
 Sitting / At a computer / Standing / Walking / Lifting & Carrying / Other \_\_\_\_\_

**Women:**  
 Are you **pregnant**? \_\_\_\_\_ When was your most recent period? \_\_\_\_\_  
 Have you ever been pregnant? \_\_\_\_\_ Number of: Live births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_  
 Are you trying to get pregnant? \_\_\_\_\_ For how Long? \_\_\_\_\_ Interventions: \_\_\_\_\_  
 Date of last gynecological exam: \_\_\_\_\_ Breast Imaging: \_\_\_\_\_ type: \_\_\_\_\_  
 How old are your children? \_\_\_\_\_ Last Birth/Miscarriage/Abortion: \_\_\_\_\_

Do you have **PMS**? \_\_\_\_\_ Moodiness/Emotional? \_\_\_\_\_ Bloating? \_\_\_\_\_  
 Sleep changes? \_\_\_\_\_ Unusual dreams? \_\_\_\_\_ Back/Belly Aches? \_\_\_\_\_ Breast Swelling? \_\_\_\_\_

Are your **periods** regular? \_\_\_\_\_ How many days between first day of periods? \_\_\_\_\_  
 How old were when you had your first period? \_\_\_\_\_ Final Period? \_\_\_\_\_  
 During your period: Cramps? \_\_\_\_\_ Clots? \_\_\_\_\_ Heavy flow? \_\_\_\_\_ Scanty flow? \_\_\_\_\_ # of days: \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ What form of birth control do you use? \_\_\_\_\_

**Men:**  
 Last Prostate exam: \_\_\_\_\_ Enlarged Prostate? \_\_\_\_\_ Prostate cancer? \_\_\_\_\_  
 Urinary problems: Dribbling urine? \_\_\_\_\_ Slow start of stream? \_\_\_\_\_ Burning? \_\_\_\_\_  
 Erectile difficulty? \_\_\_\_\_ Testicular pain/swelling? \_\_\_\_\_ Testicular Cancer? \_\_\_\_\_

**MEDICAL HISTORY** – This is a big list; read through it and check only the items that apply to you.  
Please leave everything else blank.

**Please write any details on the back of the page.**

**Brain**

- ADD/ADHD
- Anxiety/ Nervousness
- Autism
- Bi-Polar disorder
- Dementia
- Depression
- Dizziness/Vertigo
- Emotional problems
- Insomnia
- Panic attacks
- Schizophrenia/  
Schizoaffective disorder
- Sleep disturbances
- Tooth grinding/TMJ
  
- Epilepsy/Seizures
- Migraine
- Neuritis
- Paralysis
- Stroke

**Eye & Ear**

- Dry eyes/Excess tearing
- Earaches
- Eye/Visual problems
- Glaucoma
- Ringing in the Ears

**Immune and Lung**

- Allergies/Hay fever
- Asthma
- Bronchitis
- Cough
- Eczema
- Emphysema
- Hives
- Pleurisy
- Pneumonia
- Rashes
- Shortness of breath
- Sinus congestion
- Tuberculosis
  
- Lupus
- MS or other degenerative  
disease
- Rheumatoid arthritis
- Organ transplant
- Other autoimmune disease

**Kidney**

- Blood in urine
- Dribbling urination
- Frequent urination
- Incontinence
- Kidney disease
- Kidney stones
- Painful urination
- Urinary Tract Infections

**Blood**

- Anemia
- Aneurism
- Angina pectoris
- Bruise easily
- Chest pain
- Heart disease
- Hemophilia
- High/Low blood pressure
- Nose bleeds
- Pacemaker
- Palpitations
- Varicose veins

**Pain**

- Arm pain
- Arthritis
- Back pain upper/mid/lower
- Bursitis
- Disc problems
- Fibromyalgia
- Headaches
- Joint pain
- Leg pain
- Muscle spasms or cramps
- Neck pain
- Osteoporosis/Bone loss
- Pinched nerves
- Scoliosis
- Shoulder pain
- Hip pain
- Knee pain

**Liver**

- Cirrhosis
- Gall stones
- Hepatitis A/B/C
- Liver problems

**Women**

- Breast/Nipple discharge
- Breast pain
- Hot flashes
- Hysterectomy
- Impotence
- Menopause symptoms
- Menstrual problems
- Night sweats
- Ovarian cysts
- PMS
- Painful intercourse
- Prostate problems
- Testicular pain/swelling
- Vaginal dryness
- Vasectomy/Tubal ligation

**Digestive track**

- Blood in stools
- Constipation
- Crohns disease
- Diarrhea
- Excess appetite
- Frequent hunger
- Gas/Belching
- Heartburn/Reflux
- Hemorrhoids
- Hernia
- Irritable Bowel Syndrome
- Loss of appetite
- Nausea/Vomiting
- Stomach ulcers
- Ulcerative colitis

**Other**

- Cancer \_\_\_\_\_
- Candida
- Chronic fatigue syndrome
- Diabetes Type 1 or 2
- Edema
- Fatigue
- Get sick easily
- HIV/AIDS
- Hypoglycemia
- Hyper/Hypo thyroid
- Obesity
- Poor/Slow wound healing
- Unexplained weight loss

**This is as complete a health history as I can give:**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A - ACHE

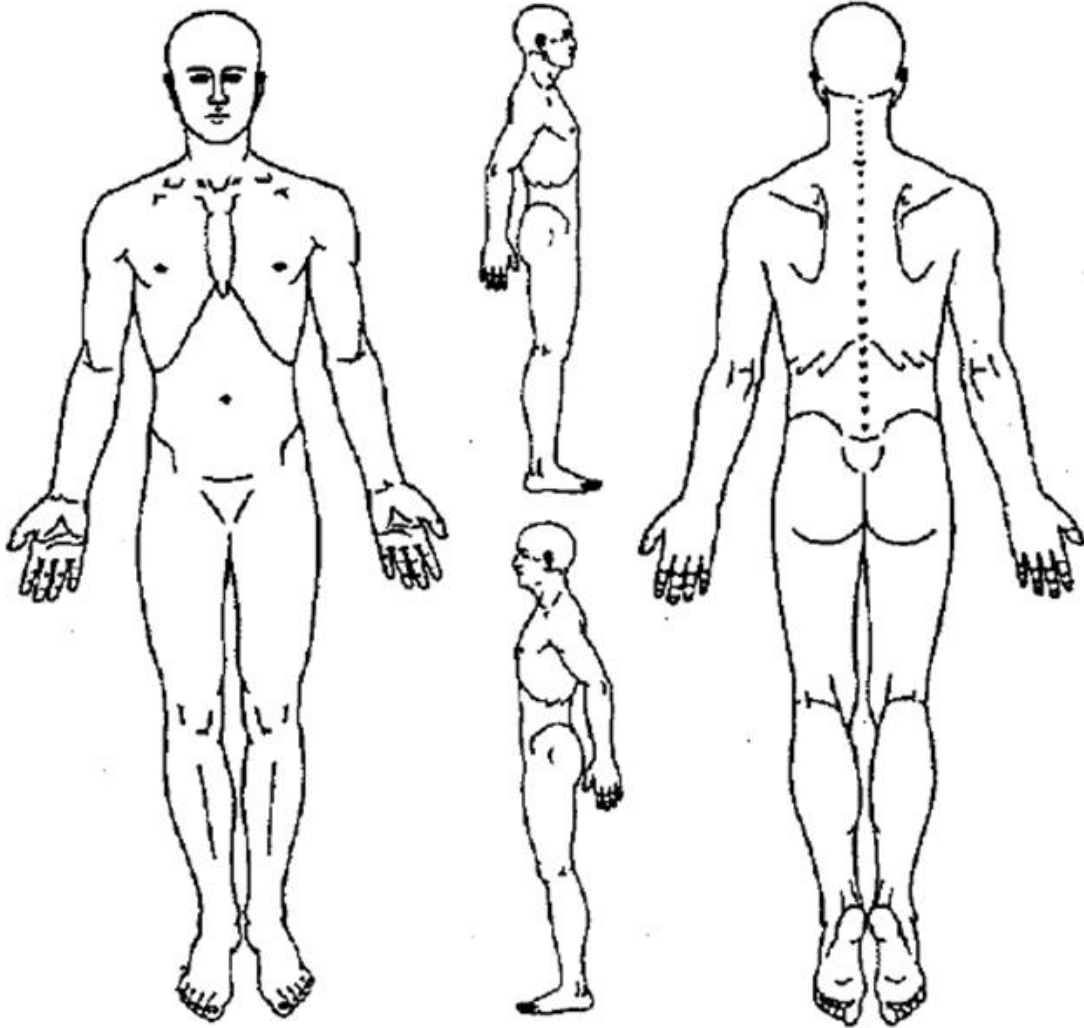
P - PINS & NEEDLES

B - BURNING

S - STABBING

N - NUMBNESS

O - OTHER



### PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

