Intake Form

Sandra L. Richard, MS, CA

Name _____ Date _____

Address _____ Date of Birth _____

_____ E-mail _____

Home Phone _____ Referred by _____

Work Phone _____ Physician _____

Cell Phone_____ Dr's Address_____

Have you had acupuncture before? Y / N For what condition? _____

What do you want treated with acupuncture now? _____

How long have you had this condition? _____ Onset sudden / gradual

Symptoms are relieved by _____

Symptoms are made worse by _____

Medical diagnosis _____

Prescription Medications _____

Nutritional Supplements _____

In general, do you feel hot or cold? _____

Do you prefer hot or cold drinks? _____

Family Health History

	Father	Mother	Sisters	Brothers	Children	Gr'mas	Gr'pas
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer / Tumor							
Drug Abuse							
Heart Disease / Heart Attack							
High Blood Pressure							
Kidney / Bladder Disorder							
Psychiatric Condition							
Seizures							
Stomach / Intestinal Disorder							
Stroke							
Autoimmune Disorder							
Other:							

Personal Health History

O Alcoholism / Drug Abuse	O Hepatitis A / B / C (circle)	O Pacemaker	O Allergies
O Asthma	O Herpes	O Polio	List Allergens:
O Birth Trauma (Yours)	O HIV / AIDS	O Rheumatic Fever	_____
O Cancer / Tumors	O Latex allergy	O Scarlet Fever	
O Diabetes	O Lyme's Disease	O Seizures	_____
O Emphysema	O Lupus	O Thyroid Problem	
O Heart Disease	O Multiple Sclerosis	O Tuberculosis	_____

List all previous surgeries (including removal of appendix / tonsils) and any major illnesses / injuries:

Approximate Date:	Event:
_____	_____
_____	_____
_____	_____
_____	_____

Please indicate areas of tension, pain or discomfort:

Please locate and describe any headaches that you experience:

Circle those items, which you have currently. **Check** those items, which you have had in the past.

Cardiovascular
O Chest pain / tightness
O High blood pressure
O Low blood pressure
O Palpitations
O Phlebitis
O Rapid heart beat

Emotions / Sleep
O Anxiety / panic attacks
O Depression
O Fatigued
O Frequent dreams / nightmares
O History of psychiatric treatment
O Insomnia
O Irritability
O Night sweating

Eyes / Ears
O Blurred vision
O Red / dry / itchy eyes
O See spots
O Ear infections
O Dizziness
O Ringing in ears
O Poor hearing

Female
O Breast lumps / disorders
O Clotting with menses
O Frequent vaginal infections
O Frequent vaginal discharge
O Irregular periods
O Light flow / heavy flow
O Menopausal symptoms
O Ovarian cysts
O Uterine fibroids
O Painful periods
O Premenstrual symptoms
Avg. # of days in full cycle:
Avg. # of days of menstruation:

Gastrointestinal
O Abdominal pain / bloating
O Acid reflux
O Belching / gas
O Blood in stool
O Constipation
O Diarrhea
O Food cravings
O Gallbladder disorder
O Hemorrhoids
O Hernia
O Nausea / vomiting
O Painful / hard stool
O Poor appetite
O Excess hunger
O Ulcer

Headaches
O At night
O During day
O Improved by rest
O Sharp
O Dull

Male
O Genital discharge
O Genital pain / itching
O Impotence
O Prostate condition

Musculoskeletal
O Abnormal spinal curve
O Backache
O Joint disorder / swelling
O Neck pain / stiffness
O Numb / tingling in limbs
O Repetitive strain
O Sore / tight muscles
O Spinal condition
O Spinal surgery
O Tendinitis

Nose / Throat / Mouth
O Bleeding gums
O Cold sores
O Frequent sore throat
O History of dental problems
O Sinus infections
O Thirsty
O No thirst
O Toothaches
O TMJ problem
O Oral herpes
O Oral surgery
Do you smoke? Y / N
When did you start?

Skin
O Acne
O Bruise easily
O Dry skin
O Eczema
O Hives / rashes
O Itchy skin
O Unusual sweating

Respiratory
O Asthma
O Chest constriction
O Chronic runny nose
O Chronic cough
O Cough with blood
O Cough with phlegm
O Dry cough
O Frequent colds

Urinary
O Burning urination
O Frequent urination
O Kidney stones
O Painful urination
O Weak stream
O Urinary tract infections