PATIENT INTAKE FORM *Date*

About You

Full Name _____ Sex M ☐ F ☐

Date of Birth _____ Place & Time of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Email _____

Home Phone _____ Other Phone _____ Cell ☐ Home ☐ Work ☐

Emergency Contact _____ Phone # _____

Marital Status S ☐ M ☐ D ☐ W ☐

Primary Physician/ Referring Physician _____

How Did You Hear About Us? _____

About Your Concerns

What would you like us to help you with? _____

Have you been given a diagnosis for your concern? Explain _____

When did the issue begin? _____

What are the precipitating factors? _____

What makes the concern worse? _____

What makes the concern better? _____

To what extent does this concern interefere with your daily activities? _____

What kinds of treatment have you tried for the concern? _____

Have you tried acupuncture before? _____

Does anyone in your family have the same concern?

About Your Nutrition

How many ounces of water do you drink a day? _____

How many caffeinated beverages a day? _____

How many alcoholic beverages a day? _____ A week? _____

Do you eat a special diet? Explain. _____

Please describe your average daily diet

Breakfast _____ Lunch _____

Dinner _____ Snacks _____

Additional Information About You

Height _____ Weight _____

Weight (1 yr ago) _____ Weight (at Max) _____ When _____

Do you smoke? _____ What? _____ Since When? _____

Describe any use of drugs for non-medical purposes _____

Allergies? _____

Describe your exercise routine _____

How many hours do you sleep a night? _____ Time you go to bed? _____

What type of work do you do? _____

Do you work indoors ☐ outdoors ☐

Occupational stressers? (chemical, physical, psychological) _____

What is your favorite season or type of weather? _____

Is any type of weather difficult for you physically or emotionally? _____

When you get out of balance emotionally, which describes your mood anger ☐ fear ☐

worry/over thinking ☐ sadness/grief ☐ agitation/anxiety ☐

About Your Medical History

List ***medications*** taken in the past 2 months: including ***vitamins***, ***over the counter remedies*** and ***herbs***.

Mark all of ***Conditions*** that apply, including ***Year Diagnosed*** and ***Medication***

Year Diagnosed		*Medicine*		*Year Diagnosed*		*Medicine*	
_____	Fibromyalgia	Y	N	_____	Kidney	Y	N
_____	Thyroid	Y	N	_____	Ulcer	Y	N
_____	HIV/AIDS Positive	Y	N	_____	Arthritis	Y	N
_____	Digestive	Y	N	_____	Neuromuscular	Y	N
_____	Breathing Problems	Y	N	_____	Psychological Issues	Y	N
_____	High Blood Pressure	Y	N	_____	Hepatitis	Y	N
_____	Cancer	Y	N	_____	Seizures	Y	N
_____	Venereal Disease	Y	N	_____	Anemia	Y	N
_____	Tuberculosis	Y	N	_____	Gallbladder	Y	N
_____	Heart	Y	N	_____	High Triglycerides	Y	N
_____	Lung/Pulimary	Y	N	_____	Osteoporosis	Y	N
_____	Diabetes Mellitus	Y	N				

About Your Medical History Continued

List all of your ***Surgeries, Hospitalizations*** and ***Signifigant Trauma's***

Year	*Event*

Check any additional ***Symptoms*** that apply to you & explain ***Other***

Head
- Headaches
- Migraines
- Dizziness
- Memory loss
- Concussions
- Other

Eyes
- Blurred Vision
- Pain
- Dryness
- Seeing Spots
- Redness
- Glasses/Contacts
- Eyestrain
- Color Blindness
- Night Blindness
- Cataracts
- Other

Ears
- Poor Hearing
- Ringing
- Frequent Infections
- Other

Respiration
- Asthma
- Bronchitis
- Chest Pain
- Cough / Coughing Blood
- Emphysema
- Other
- Difficulty Breathing
- Phlegm
- Pneumonia
- Wheezing
- Other

Heart and Thorax
- Palpitations
- Rapid Heart Beat
- High Blood Pressure
- Low Blood Pressure
- Tightness in Chest
- Arteriosclerosis
- Heart Attack
- Other

Circulation
- Bruise Easily
- Cold Hands and Feet
- Fainting
- Anemia
- Phlebitis
- Varicose Veins
- Other

Gastrointestinal
- Poor appetite
- Bad Breath
- Excessive Hunger
- Excessive Thirst
- Belching or Heartburn
- Colitis or IBS
- Gas
- Abdominal Pain
- Parasites
- Nausea
- Constipation
- Diarrhea
- Chronic Laxative Use
- Blood In Stools
- Black Stools
- Hemorrhoids
- Stomach Pain
- Rectal Pain
- Other

Emotional
- Depression
- Mania / Bipolar
- Anxiety
- Temper
- Mood Swings
- Stressed
- Other

About Your Medical History Continued

Check any additional ***Symptoms*** that apply to you & explain ***Other***

Mouth
- Gum Problems
- Teeth Problems
- Tongue / Lip Sores
- Jaw Clicking / Pain
- Unusual Tastes
- Other

Energy Level
- Low Energy
- Excessive Energy
- Hard to Wake Up
- Energy Drop in the PM
- Sudden Energy Drop
- Other

Neuromuscular/Skeletal
- Stiff Neck
- Low Back Soreness
- Shoulder Trouble
- Spinal Curvature
- Paralysis
- Knee Trouble
- Swollen Joints
- Painful Joints
- Hip Pain
- Arthritus
- Hand / Wrist Pain
- Knee Pain
- Sprain
- Hernia
- Sciatica
- Numbness / Tingling
- Other

Skin
- Rashes
- Change in texture
- Dryness
- Dandruff
- Eczema
- Hairloss
- Sweating
- Hives
- Itching
- Night Sweats
- Pimples
- Purpura
- Recent Moles
- Other

Throat
- Sore Throat
- Difficulty Swallowing
- Thyroid Issues
- Other

Nose
- Frequent Colds
- Sinus Troubles
- Nosebleeds
- Drainage
- Other

Men's Issues
- Prostate Problems
- Discharge
- Impotence
- Frequent Emissions
- Fertility Problems
- Ejaculatory Issues
- Painful Testicles
- Swollen Testicles
- Other

Sleep
- Insomnia
- Drowsiness
- Night Sweats
- Sleep Walking
- Excessive Dreaming
- Other

Women's Issues
- Painful Periods
- Cramps / Backache
- Fertility Problems
- Ovarian Cysts
- Excessive Flow
- Endometriosis
- Low Sex Drive
- Light Flow
- Clotting
- Irregular Cycle
- Hot Flashes
- Discharge
- Faibrocystic Breasts
- Breast Tenderness
- PMS
- Bleeding
- Low Sex Drive
- Other

Urogenital
- Frequent Urination
- Difficult Urination
- Burning Urination
- Itching of Genitals
- Frequent UTI's
- Waking to Urinate
- Pause of Flow
- Retention of Urine
- Dribbling of Urine
- Bedwetting
- Other

About Your Medical History Continued

Female Patients**,** please answer the following:

Number of Pregnancies	_____	Number of Births	_____
Number of Miscarriages	_____	Number of Abortions	_____
Premature Births	_____	Cesarian Sections	_____
Age of First Mensus	_____	Duration of Periods	_____

Do you practice birth control ☐ No ☐ Yes, Type _____

About Your Family Medical History

Indicate the ***items below***, if any, that apply to your family

	Family Member
Cancer	
Hypertension	
Alcoholism	
Diabetes	
Heart Disease	
Hepatitus	
Miscarriage	
Stroke	
Autoimmune Disease	
Asthma	

Your Informed Consent to Treatment

I hereby request and consent to the performance of acupunture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named within, for whom I am legally responsible) by the acupuncturist named within and / or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back up for the acupuncturist named within, including those working at the clinic or office listed within or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupunture, moxibustion, cupping, electric stimulation, TIU-NA (Chinese Massage), Chinese herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and the tea's consumed accordingly to the instructions provided orally and in writting. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant affects associated with the consumption of the herbs.
I have been informed that acupunture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, infection, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupunture include sponstaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Although the clinic uses sterile disposable needles and maintains a clean and safe enviornment. Burns and / or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member if I become pregnant.Some possible side effects of taking herbs are nausea, gas, stomach ache, vomitting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and adminstrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
By voluntearily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupunture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ ***Date*** _____

(Or Authroized Parent / Guardian if patient is under 18)

Print _____