Patient Intake / Acupuncture
Allergy Elimination

Date_____________ 200____

Name ____
Date Of Birth __________________________M__F___
Home Address ____
City ______________________ State ______ Zip _______
Home phone ______________ Cell phone________________________
E-mail____
Married __ Single__ Social Security # __________________
Occupation ____
Employer________________________City____________State______
Zip_____ Work phone______________
What is the best way to contact you? _________________________
Who can we thank for referring you?__________________________
Have you ever had Acupuncture before?____With who?_____________

Massage, acupressure, acupuncture, reflexology, preventative or corrective exercise, and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for western medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you consult your physician, for any serious conditions and get at least two medical opinions. It is your right and your responsibility for your own body.

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

I understand that complications may result from acupuncture treatment. Among these possible complications are: Areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms.

Client further understands and agrees to hold harmless, to indemnify and protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury an these premises.

Signed:____ Date:_____________________

Name:____**Date:**___________

Major complaint (reason for visit)____
____

Have you ever had this condition or similar condition before? **O** Yes **O** No
Have you ever received treatment for this condition? If yes, when? By whom?
____
____

What was the diagnosis? What were the results of the treatment?
____
____

Has the condition gotten: **O** Better **O** Worse **O** Same
What makes it better?____
____

What makes it worse?____
____

Describe what caused it and how it started.______________________________________
____
____

Family Medical History:
O Cancer **O** Diabetes **O** High or low Blood pressure **O** Heart Trouble **O** TB **O** Asthma
O Allergies **O** Kidney disease **O** Epilepsy **O** Liver Disease **O** Ulcers **O** Sinus Problems
O Eye Disease **O** Arthritis **O** Alcoholism **O** Spinal Problems **O** Mental Disorder
O Drug Addiction Other:____

Personal Medical History:
(Include dates) Major Surgeries – Illness (from list above) – Diseases – Accidents: ___________
____
____
____

Medications recently taken: ____
____

Known Allergies: (drugs, chemicals, foods, animals, seasonal, etc…)
____
____
____
____
____
____
____

Contagious Diseases History:
O HIV **O** AIDS **O** Hepatitis **O** Venereal Disease **O** Herpes Other______________________

Habits:
O Cigarettes **O** Soft Drinks **O** Salt **O** Coffee **O** Alcohol **O** Recreational Drugs
O Black Tea **O** Sugar **O** Artificial sweeteners **O** Marijuana **O** Occupational Hazards
Other:______________________________

Exercise:
O Never **O** Little **O** Moderate **O** Heavy Type of exercise:___________________________
____

Emotional:
O Happy **O** Easily Irritable **O** Difficulty Making Decisions **O** Angry **O** Cry easily **O** Stressed
O Hurry to do things **O** Depression **O** Restless Other:___________________________________

Diet (Typical foods eaten):
O Beef **O** Eggs **O** Cheese **O** Grains **O** Tofu **O** Pork **O** Bread **O** Margarine **O** Fried Foods
O Yogurt **O** Poultry **O** Milk **O** Ice Cream **O** Sweets **O** Fish **O** Butter **O** Vegetables **O** Salads
O Health Foods **O** Diet foods **O** Spicy foods **O** Fast Foods Other:________________________

Appetite:
O Up & down **O** Poor **O** Good **O** Hungry a lot **O** Loss of taste
Do you eat 3 meals per day? **O** Yes **O** No Do you eat at regular hours? **O** Yes **O** No
Cravings:____

Weight:
O Normal **O** Underweight **O** Overweight **O** Recent gain **O** Recent Loss

Energy:
O Up & down **O** Low **O** Normal **O** excess **O** Low after eating **O** Tired in afternoon
Other:____

Body temperature:
O Warm natured **O** Flushed face **O** Feel warmer late afternoon & night **O** Sweat easily
O night sweats **O** Cold natured **O** Warm palms **O** Alternate chills & fever
O Profuse perspiration **O** cold hands & feet **O** Warm soles **O** Normal Other:______________
____

Digestion:
O Indigestion **O** Bloating **O** Heartburn **O** Nausea **O** Vomiting **O** Full feeling or distention
O Belch or burp **O** Abdominal pain or cramps **O** Gas **O** Difficulty digesting fatty or oily foods
O Bitter taste in mouth **O** Gallstones **O** Normal Other:_________________________________

Bowels:
O Loose stools **O** Diarrhea **O** Hemorrhoids **O** Constipation **O** Colon problems
O Use Laxative **O** Pain or cramps **O** Normal Other:_____________________________________

Urination: (3-4 times per day is normal)
O Frequent **O** Burning **O** Bladder infections **O** Urgency **O** Nighttime **O** Incontinence
O Kidney stones or Infection **O** Normal Other:____

Thirst:
O Less than normal **O** Prefer cold drinks **O** Thirsty but do not drink **O** Prefer hot drinks
O Excessive **O** Normal #Glasses per day_____ Other _________________________________

Sleep:
O Difficulty falling asleep **O** Lots of dreams **O** Tired in morning **O** Awake easily **O** Restless
O Nightmares **O** Sleep too much **O** Difficulty going back to sleep **O** Normal
Average # hrs a night _____ Other____

Headaches-Dizziness:
O Headaches **O** Vertigo **O** Bend down and stand up and get dizzy **O** Dizziness **O** Migraines
O Motion sickness **O** Poor balance **O** Faint easily **O** Poor memory Other_________________

Skin:
O Dry **O** Hives **O** Itchy **O** Oily **O** Acne **O** Bruise easily **O** Eczema **O** Rashes
O Cuts heal slowly **O** Normal Other____

Hair:
O Dry **O** Oily **O** Dandruff **O** Falling out **O** Early grey **O** Normal Other______________

Nails:
O Soft **O** Spots **O** Grow slowly **O** Ridges and lines **O** Purple **O** Break easily **O** Grow fast
O Pale **O** Normal Other____

Eyes:
O Wear glasses or contacts **O** Eyelids swollen **O** Red **O** Dry **O** Itch **O** Poor night vision O Pain
O Twitch **O** Sensitive to light **O** Color blindness **O** Tear easily **O** Normal Other___________

Ears:
O Poor hearing **O** Ringing (high pitch) **O** Ringing (low pitch) **O** Discharges **O** Ear aches
O Normal Other____

Nose:
O Stuffy nose **O** Hayfever **O** Sneeze a lot **O** Environmental sensitivity **O** Mucous **O** Bleeding
O Loss of smell **O** Blow nose a lot **O** Sinusitis **O** Rhinitis **O** Normal Other_______________

Mouth & Throat:
O Dry **O** Gum problem **O** Frequent colds **O** difficulty swallowing **O** TMJ **O** Thyroid problem
O Feel lump in throat **O** Grind teeth **O** Normal Other__________________________________

Respiratory:
O Shortness of breath **O** Difficulty inhaling **O** Sigh a lot **O** Chest pain **O** Difficulty exhaling
O Dry cough **O** Asthma **O** Difficulty breathing **O** Cough with phlegm **O** Bronchitis
O Wheezing **O** Emphysema **O** Cough with blood **O** Tightness in chest **O** Normal
Other____

Cardiovascular – Circulation:
O Diagnosed heart problems **O** Palpitations **O** Low blood pressure **O** High blood pressure
O Bleed easily **O** High cholesterol **O** Murmur **O** Varicose veins **O** Ankle/hand swelling
O Chest pain **O** Bruise easily **O** Irregular heart beat **O** Numbness in extremities **O** Normal
Other____

Pain:
O Low back pain **O** Shoulder **O** Muscle weakness **O** Sciatica **O** Hands or wrists **O** Mid back
O Muscle cramps **O** Upper back **O** Hips **O** Muscle twitching or spasm **O** Knees **O** Neck
O Foot or ankle **O** Nerve **O** Spine **O** Arthritis **O** Damp weather pain **O** Abdomen/ ribs/sides
Other____

Any other problem you would like to discuss?________________________
____
____
____
____
____

Patient signature____**date**____________

***** For Females Only*****

Are you or might you be pregnant? **O** Yes **O** No **O** Maybe? Approximate date of conception___

Are you experiencing reduced sex drive? **O** Yes **O** No Other difficulties____________________
____

Do you have regular PAP tests? **O** Yes **O** No How regular?_____________________________

Do you have regular breast exams? **O** Yes **O** No How regular?__________________________

Do you have facial hair or excess body hair? **O** Yes **O** No

Menstrual Cycle:
Age started____ Days of flow____ Age stopped____

How many days from the beginning of your period to the start of your next period?____________

Check what applies to your period:
O Irregular Cycle **O** Water retention **O** Heavy flow **O** Scanty flow **O** Dark color flow **O** Painful
O Light color flow **O** Clotting **O** Excessively painful or tender breasts **O** Breast lump
O Emotional changes **O** Spotting between periods **O** Lump in throat feeling **O** Constipation
O Diarrhea **O** Tightness in chest **O** Hormonal problems **O** Backache **O** Sigh a lot **O** Cramps
Other____

Vaginal discharge:
O Yellow **O** Thick **O** Bad odor **O** White **O** Clear Other______________________________

Ovulation Symptoms:____
Menopause Symptoms:____
____
Pregnancies:
Total number ____ Number of miscarriages ____ Number of children ____

Pregnancy or Childbirth Complications____
____
Gynecological History and Operations:
O Ovaries____
O Uterus____
O Fallopian tubes____
O Vagina____
O Breasts____
O Other____

What method of Birth Control do you now use?_____________________________________
What method of Birth control have you used in the past?____________________________
____

Signature:____ Date:___________________