Patient Intake Form

Patient _____ Birth Date __/__/____ Tel # ___-___-____
Email _____ Referring Physician _____ Tel # ___-___-____
Address _____

History:

Chief Complaint _____
History of Illness:
How Long ?_____ When does it hurt ? _____
Pain is where ? _____ What makes it better ? _____
What makes it worse ? _____ Any other issues with the pain ? _____

Med History:

Diabetes	y / n	Previous Hospitalizations _____
Hypertension.....	y / n	_____
Cancer.....	y / n	_____
Stroke.....	y / n	Medications _____
Heart Issues.....	y / n	_____
Arthritis/Gout.....	y / n	_____
Convulsions.....	y / n	_____
Migraines.....	y / n	
Bleeding tendency	y / n	
Infections.....	y / n	
Hereditary defects.....	y / n	
Venereal disease.....	y / n	

Social History:

Marital Status Single __ Married __ Separated __ Divorced __ Widowed __
Use of Alcohol Social __ Daily __ Never __
Use of Tobacco Never __ Daily __ Pack/day __ Only when drinking __ quit __
Use of non prescribed drugs Never __ Type/Frequency _____
Environmental exposure Smoke __ Dust __ Noise __Chemicals __ Stress __

Family History:

Father _____ Living ? _____
Mother _____ Living ? _____
Siblings _____ Living ? _____

The above has been reviewed by the acupuncturist. _____

Patient Intake Form

Name _____

Systems Review:

Constitutional Symptoms
- General good health ..... y / n
- Recent weight change ..... y / n
- Fever ..... y / n

Eyes
- Eye disease ..... y / n
- Wear glasses ..... y / n
- Blurred or double vision ..... y / n

Ears Nose Throat
- Earaches..... y / n
- Tinnitus - ringing ..... y / n
- Ear discharge ..... y / n
- Chronic sinus ..... y / n
- Nose Bleeds ..... y / n
- Mouth sores ..... y / n
- Bleeding gums ..... y / n
- Bad breath ..... y / n
- Soreness in throat ..... y / n
- Voice problems ..... y / n

Cardiovascular
- Heart trouble ..... y / n
- Chest pain ..... y / n
- Palpitations ..... y / n
- Shortness of breath ..... y / n
- Edema of extremities ..... y / n

Respiratory
- Chronic coughing ..... y / n
- Spitting blood ..... y / n
- Asthma or wheezing ..... y / n

Gastrointestinal
- Loss of appetite ..... y / n
- Change in bowel movements... y / n
- Nausea / vomiting ..... y / n
- Diarrhea ..... y / n
- Blood in stool ..... y / n
- Constipation ..... y / n
- Abdominal pain / heartburn ..... y / n
- Ulcers ..... y / n
- IBS ..... y / n

Genitourniary / OBGYN
- Frequent urination..... y / n
- Burning or painful urination ..... y / n
- Blood in urine ..... y / n
- Incontinence / dribbling ..... y / n
- Kidney stones ..... y / n
- Libido issues / ED problems ..... y / n
- (F)...menstrual pain ..... y / n
- (F)...irregular periods ..... y / n
- (F)...clotting ..... y / n
- (F)...cramps ..... y / n
- (F)...irritability PMS ..... y / n
- (F)...discharge ..... y / n
- (F)...yeast infections ..... y / n
- (F)... # pregnancies ___ # births _____
- (F)...date of last period __/__/____

Musculoskeletal
- Joint Pain ..... y / n
- Weakness of muscles ..... y / n
- Muscle pain / cramps ..... y / n

Integumentary (skin)
- Rash / itching ..... y / n
- Changes in skin color ..... y / n
- Brittle or discolored nails ..... y / n
- Cuts slow to heal ..... y / n

Neurological
- Headaches ____ Frequency _____
- Dizziness..... y / n
- Neuroma / Nerve pain / Shingles... y / n
- Trembling ..... y / n
- Memory problems ..... y / n
- Unexplained fears ..... y / n
- Insomnia ..... y / n

Endrocrine
- Glandular / hormonal problems .... y / n
- Thyroid disease ..... y / n
- Autoimmune disease..... y / n

Hematological / Lymphatic
- Bruising ..... y / n
- Enlarged glands ..... y / n

Allergic / immunologic

Drug / food reactions _____

_____

_____

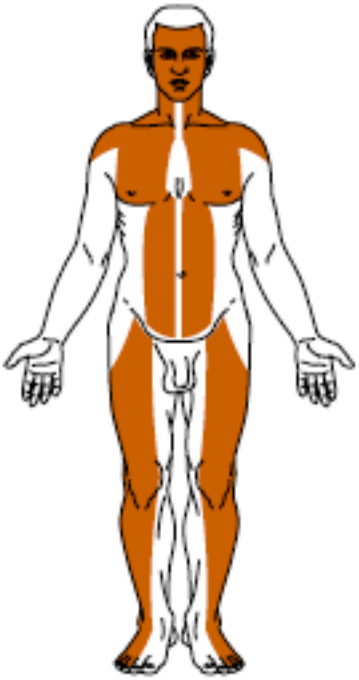
The above has been reviewed by the acupuncturist. _____

Patient Intake Form

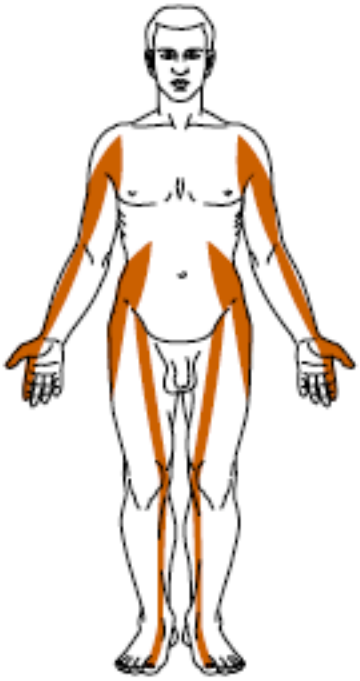
circle areas of pain

Taiyang

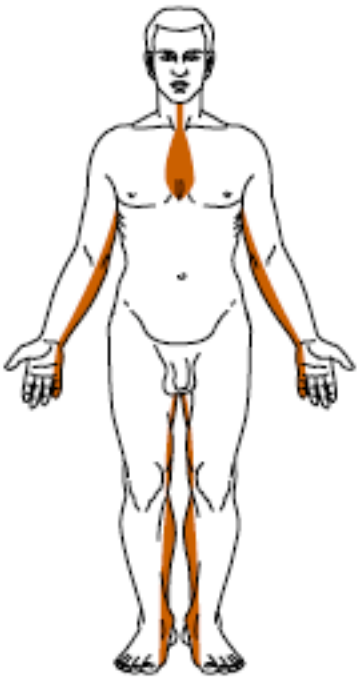
Shaoyang



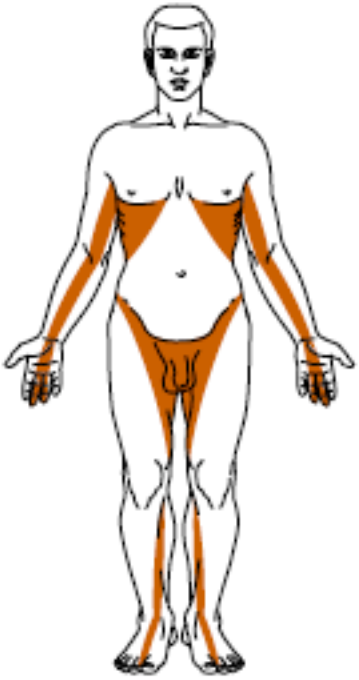
Yangming



Taiyin



Shaoyin



Jueyin

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