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CLIENT INFORMATION

Client Name: _____

If Patient is a Minor, Guardian's Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Telephone Number: _____ Secondary # _____

Email (please write legibly): _____

Emergency Contact Information : Name: _____

Telephone Number: _____ Relationship: _____

Date of last physical exam: ____/____/____ Physician: _____

Have you ever received acupuncture before? _____ What other type of treatment are you currently receiving? _____

REASONS SEEKING TREATMENT

There will be ample time during your initial intake to elaborate on the following questions.

1. What are the main health problems for which you are seeking treatment? _____

_____

How long have you had this condition? _____The onset was ▫__ sudden ▫__ gradual

Medical diagnosis, if any? _____

Please rate the extent which your current complaint affects daily life (1 = minor; 10 = major)_____

What other forms of treatment have you sought, and what were your results? _____

_____

2. What are the main health problems for which you are seeking treatment? _____

_____

How long have you had this condition? _____The onset was ▫__ sudden ▫__ gradual

Medical diagnosis, if any? _____

Please rate the extent which your current complaint affects daily life (1 = minor; 10 = major)_____

What other forms of treatment have you sought, and what were your results? _____

_____

MEDICATIONS

Please list any medications, supplements, herbs or vitamins you are taking, including all over the counter medications:

Medications/ Supplement	Duration of usage	Dosage/ Frequency	Treating which condition?

HEALTH HISTORY

Please describe any significant injuries, surgeries, or illnesses:

Childhood: _____ Age ____

_____ Age ____

_____ Age ____

Adolescence: _____ Age____

_____ Age____

_____ Age ____

Adulthood: _____ Year____

_____ Year_____

_____ Year_____

_____ Year_____

	Self	Mother	Father	Sibling	Spouse
Cancer or tumors					
Diabetes					
Hepatitis					
HIV/ AIDS					
Other Infectious Disease					
Multiple Sclerosis					
Blood or Bleeding Disorders					
Seizures					
High Blood Pressure					
Heart Disease					
Stroke/ Blood Clots					
Thyroid Disorder					
Osteoporosis					
Lyme Disease					
Alcoholism					
Depression or mental illness					
Age of death					

Please assign a number of severity (1 = lowest, 10 = highest) to any symptoms you have experienced in the last three month. Place a P to any symptoms you have experienced in the past.

Head and Neck
__ Headaches
__ Migraines
__ Stiff Neck
__ Low Back Pain

Gastrointestinal
__ Belching
__ Nausea
__ Vomiting
__ Stomach pain
__ Gas
__ Acid regurgitation
__ Heartburn
__ Indigestion
__ Excessive hunger
__ Poor appetite
__ Bloating after meals
__ Hemorrhoids
__ Irregular bowel movements
__ Diarrhea
__ Constipation
__ Loose Stools
__ Blood in stool
__ Undigested food in stool

Average Number of Bowel Movements?
Per Day _____
Per Week _____

Respiratory, Nose, Throat and Mouth
__ Asthma
__ Allergies
__ Frequent colds (3 or more per year
__ Chronic cough
__ Coughing blood
__ Chronic runny nose
__ Frequent sore throat
__ Difficulty swallowing
__ Dry mouth
__ Sinus infections
__ Excessive phlegm
__ Nasal congestion
__ Nose bleeds
__ TMJ
__ Cold sores
__ Bleeding gums
__ Difficulty Inhaling
__ Wheezing
__ Shortness of breath
__ Emphysema

Neurological
__ Dizziness
__ Fainting
__ Loss of balance
__ Lack of coordination
__ Areas of numbness
__ Poor memory
__ Tremors
__ Numbness or tingling
__ Epilepsy/seizures
__ Concussion
__ Vertigo

Ears and Eyes
__ Ear pain
__ Ringing in ears: __ high / __ low pitch
__ Clogged / popping ears
__ Decreased hearing
__ Red eyes
__ Poor vision
__ See spots

Skin and Hair
__ Dry skin
__ Acne
__ Bruise easily
__ Skin rashes
__ Psoriasis
__ Itching
__ Eczema
__ Changes in moles or lumps
__ Hair loss
__ Premature graying
__ Night sweating
__ Excess sweating

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Palpitations
__ Chest pain
__ Irregular heartbeat
__ Varicose veins
__ Poor circulation
__ Anemia
__ History of heart attack

Genito-Urinary
__ Pain on urination
__ Frequent urination
__ Urgent urination
__ Blood in urine
__ Incomplete urination
__ Decreased libido
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Lumps in testicles
__ Pain/ itching of genitalia

__ History of sexually transmitted disease:
__ self/ __ partner
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Herpes: _ Oral/ _ Genital

Sleep
What time do you go to bed?_____
What time do you wake? _____
Do you feel refreshed when you wake?_____
Do you have trouble
____Falling asleep
____Staying Asleep
____Nightmares
____Disturbed Sleep

LIFESTYLE

Food and Drink: Please Describe Typical Meals:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

Do you have any food cravings? _____

List any food intolerances: _____

What % of your diet is organic? _____

On average, how often are you consuming?

	Days per week?	More then once a day?
Red meat		
Fast food		
All vegetables		
Leafy green vegetables		
Products made of wheat flour		
Dairy		

In ounces, how much plain water are you drinking? _____ ounces (A typical glass is 8oz, a Nalgene bottle is 32 oz)

What else are you drinking? _____

Caffeine	_____# of coffees per day _____# of teas per day _____# of sodas per day	
Tobacco	_____# of cigarettes/cigars per day	Age began use? Stopped when?
Alcohol	_____ Average drinks per day? _____ Per Week?	Age began use? Stopped when?
Marijuana	Specify Frequency	Age began use? Stopped when?
Hard drugs (cocaine, crack, heroin, LSD, etc.)	Specify Frequency	Age began use? Stopped when?

Systems

Energy and Temperature:

What is your energy level (From 1 = lowest to 10 = highest)? _____

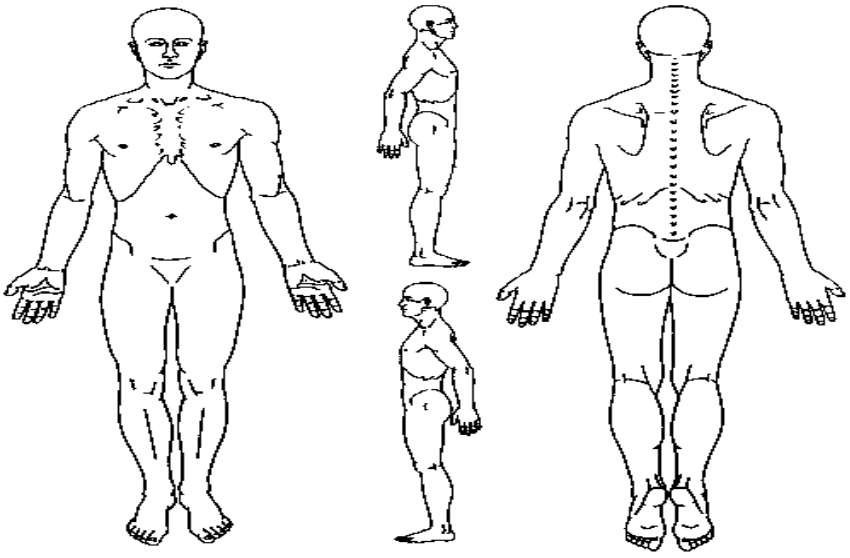
What time of day is your energy: Highest? _____ Lowest? _____

What kind of exercise do you do? _____

On average how often do you exercise? _____ minutes/hrs _____ days per week.

In general, does your core feel hot or cold? _____Cold Hands & Feet? _____

Muscles, Joints and Bones:
Please indicate where you are experiencing pain.



What is the current level of pain, from 1-10? _____
Onset? _____
The pain feels worse with: _____
The pain feels better with: _____

The pain is… please check all that apply:

__ Constant	__ Dull	__ Tingling	__Aching
__ Comes and goes	__ Superficial	__ Numb	__Fixed
__ Sharp	__ Deep	__ Burning	__Moves around

Women:
At what age did you start menstruating? _____ Age at onset of menopause _____
Number of days in your cycle? _____ Duration of flow? _____
Color? _____Clots? _____Quality? (thick, thin) _____
PMS Symptoms _____
Are you *currently* pregnant? Yes _____No_____ Number of pregnancies? _____
Number of deliveries? _____Abortions/Miscarriage(s)? _____
Are you *presently* trying to get pregnant? Yes_____No_____
Have you taken any medications to enhance fertility? _____ Medication? _____
Dates/ Duration_____
Have you undergone any fertility treatments? _____ Procedures/ dates of procedues:
1._____ 2._____
3._____ 4._____

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past.

__ Heavy flow	__ Irregular menses	__ Uterine Fibroid
__ No flow	__ Discomfort f**ollowing** menses	__ Reoccurring yeast infections
__ Light flow	__ Discomfort **before** menses	__ Reoccurring UTIs
__ Spotting between menses	__ Discomfort **during** menses	__ Breast lumps

Date of last pap smear? _____ Results of the last 2 pap smears? _____