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

## Systems

**Energy and Temperature:**

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

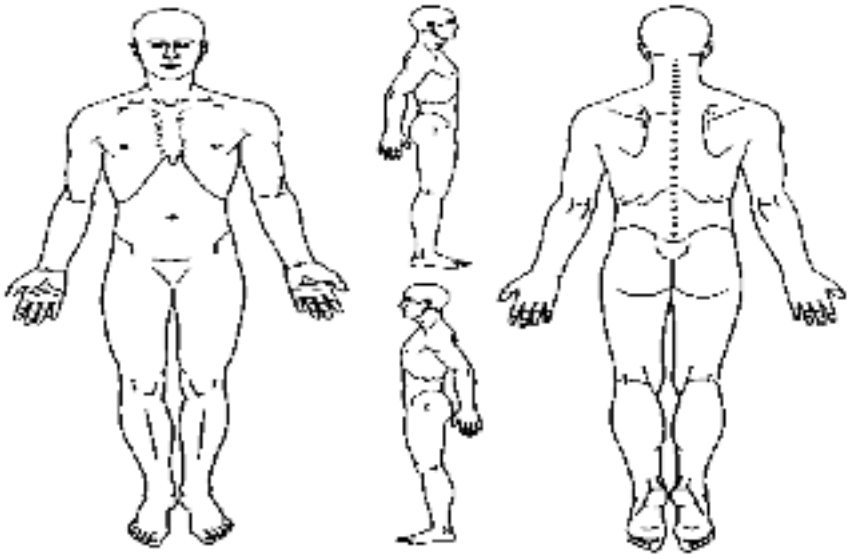
What time of day is your energy: Highest? _____ Lowest? _____

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? _____