

General Symptoms: (Please check all that apply)

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Craves cold drinks | <input type="checkbox"/> Craves hot drinks | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweat easily(describe):
_____ |
| <input type="checkbox"/> Dream-Disturbed Sleep | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Heavy Sleep | <input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Eczema
<input type="checkbox"/> Hives | <input type="checkbox"/> Easily Stressed
<input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Change in hair/skin texture |
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tight Chest | <input type="checkbox"/> Numbness | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cough: If yes, is it
<input type="checkbox"/> Wet OR <input type="checkbox"/> Dry
<input type="checkbox"/> Thick OR <input type="checkbox"/> Thin | <input type="checkbox"/> Coughing Blood
<input type="checkbox"/> Tachycardia
<input type="checkbox"/> Fainting | <input type="checkbox"/> Pneumonia
<input type="checkbox"/> Blood clots
<input type="checkbox"/> Seizures | <input type="checkbox"/> High blood pressure
<input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Intestinal Pain | <input type="checkbox"/> Bloody Stools | <input type="checkbox"/> Bowel Movements:
Frequency per day
_____ |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Impotence | |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine
<input type="checkbox"/> Lymph Nodes Removed | <input type="checkbox"/> Frequent urination
<input type="checkbox"/> Infectious Diseases: _____ | | |

Musculoskeletal: (Please check all that apply)

- | | | | | |
|---|--|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Rib Pain | <input type="checkbox"/> Muscle Spasm | _____ |

Woman Only: Gynecology

- | | | | | |
|--|--|--|--|---------------------------------|
| Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No | Duration of flow
_____ | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> PMS |
| Vaginal Discharge (Color)
_____ | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Vaginal Odor | <input type="checkbox"/> Clots | Date Last Period began
_____ |
| Length of cycle (Day 1 to Day 1)
_____ | # Pregnancies
_____ | # Live Births
_____ | Premature Births
_____ | Age at Menopause
_____ |

Please List Any Other Pertinent Information:

I agree that the information I provided on this intake is true. It is my responsibility to inform the Acupuncturist at any point of my course of treatments if any information has changed.

Signature of Patient _____ Date _____