Health Evaluation Intake Form

Dear Friend,

In order to make our evaluation as complete as possible, we ask that you take the necessary time to fill this questionnaire out as completely as possible. If you have any questions, please feel free to ask for our assistance. All answers will remain confidential.

Please print all answers. **Date:** ___________________________

Full Name: ____ **Nickname:** ______________________

Address: ____

City: ____ **State:** ______________________________ **Zip Code:** ______________________

Phone: Home _______________________________ **Work** _________________________________ **Birth Date:** _______________________

Email Address: ____

Age: ___________________ **Sex:** __________________ **Height:** _____________ **ft.**_________ **in. Weight:** ______________**lbs.**

Occupation: ____

Family Doctor: ____ **Phone:** ____

In Case of Emergency Notify: ____

Relationship to you: ____ **Phone:** ____

Referred by: ____

Have you ever had Acupuncture Therapy before? ____

What are you currently seeking treatment for? ____

How long has the condition existed? ____

Have you previously sought other types of treatments for this condition? (i.e. Nutrition, medication, surgery, exercise, etc.). Please describe.

____

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Medications: Please list any you are currently taking and why. Please also include any over the counter medicines and supplements.

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____

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Please check if you ever had or have now:

MEDICAL HISTORY

Scarlet Fever	Diphtheria	Rheumatic Fever
Chronic or Frequent Colds	Sinusitis	Tuberculosis
Heart Murmur	Heart Attack	Stomach Problems
Liver Problems	Intestinal Problems	Gall Stones
Gall Bladder Problems	Jaundice	Hepatitis
Cancer	Piles, Hemorrhoids, etc.	Kidney Stones
Blood or Albumin in Urine	Sugar in Urine	Venereal Disease
Drug or Narcotic Habit	Excessive Alcohol Use	Worn a Back Brace
Back Surgery	Worn Glasses	Eye Problems
Ear Problems	Nose Problems	Throat Problems
Anemia	Tumors, Cysts, Boils	Adverse Reaction to Drugs

SYSTEMS REVIEW:

CARDIOVASCULAR

Ankle Swelling	High Blood Pressure	Low Blood Pressure
Rapid Heartbeat	Irregular Heartbeat	Palpitations
Dizziness	Fainting Spells	Chest Pains
Leg Cramps	Heart Attack	Blood Clots
Shortness of breath during normal activity		
Poor circulation in any part of the body		
Any other heart problem not mentioned above?		

RESPIRATORY

Cough	Coughing Blood	Sore Throats
Sneezing	Excessive Sweating	Lack of Perspiration
Chest Pains	Asthma or Wheezing	Difficulty on Breathing
Bronchitis	Seasonal Allergies	Nosebleeds
Excessive Phlegm	What color?	
Any other respiratory problems not mentioned above?		

GASTROINTESTINAL

Indigestion	Abdominal Pain or Cramps	Diarrhea
Constipation	Blood in Stools	Black Bowel Movements
Gas	Belching	Hemorrhoids
Increased Appetite	Decreased Appetite	Increased Thirst
Increased Thirst	Decreased Thirst	Nausea and vomiting
Halitosis	Rectal Pain	Do you use laxatives regularly
Any other gastrointestinal problems not mentioned above?		

GENITO-URINARY

Lower Back Pain	Frequent Urination	Burning or Painful Urination
Urine Retention	Blood in Urine	Unable to hold Urine
Bladder Infections	Vaginal Infections	Kidney or Bladder Stones
Venereal Disease	Lack of Sexual Drive	Other Discharge in Urine
Any other genito-urinary problem not mentioned above?		

FEMALES ONLY

Been Treated for Female Disorders	Vaginal Discharge
Painful Menstruation	Irregular Menstruation
Breast Lumps	Breast Pain
Sores in Vaginal Area	Venereal Disease
Female Surgeries Describe:	
Age at First Menstruation	Interval Between Periods (days)
Duration of Periods (days)	Date of Last
Do you Practice Birth Control	What Method?
Date of Last Period	Normal Excessive Light
Number of Births	Number of Abortions
Number of Pregnancies	Number of Miscarriages

EYES

Wear Glasses or Contacts	Pain or Pressure in the Eyes	Color Blindness
Night Blindness	Double Vision	Blurry Vision
Eye Strain	Recent Worsening of Eyesight	Spots or Floating Lights
Cataracts		
Any other eye or vision problems not mentioned above?		

EARS

Hearing Difficulties	Earaches	Discharge from Ears
Ringing or Buzzing	Do you lose your balance easily	Ear Infections
Any other ear problems not mentioned above?		

NOSE and THROAT

Nasal or Sinus Congestion	Nasal Discharge	Nose Bleeds
Sinus Headaches	Sneezing Spells	Sore Throats
Difficulty Swallowing	Loss Sense of Smell	Sinus Infections
Nasal Polyps		
Any other nose or throat problems not mentioned above?		

MOUTH, GUMS and TEETH

Do you wear false teeth ___________________ **Do you ever grind your teeth** ______________________

Sore or bleeding gums ____________________ **Sore tongue** _____________________________________

Sores on lips or in mouth __________________ **Unusual coating on tongue** _______________________

Unusual tastes in mouth ___________________ **Describe** ____

Have you had extensive dental work in the last 6 months? ____

Describe ____

Any other mouth or dental problems not mentioned above?

____

MUSCULO-SKELETAL

Do you experience pain in your back? ___________________

Upper ___________ Middle ____________ Lower _____________

Do you experience pain in your neck? _____________________

Do you experience muscle cramps or pains? ________________

Where? ____

Pain or swelling in joints ___________________ Arthritis _______________________________________

Rheumatism ______________________________

Weakness in muscles? _____________________

Where? ____

Limpness in muscles? ______________________

Where? ____

Any other muscular or skeletal problems not mentioned above?

SKIN and HAIR

Ulcerations	Itching	Rashes
Hives	Athlete's Foot	Bruising
Pimples	Eczema	Dandruff
Falling Hair	Recent Mole, Lumps, Growths	

Any other skin or hair problems not mentioned above?

ENDOCRINE

Diabetes	Thyroid Disorder
Recent Changes in Pigmentation	Recent Changes in Distribution of Body Hair

MISCELLANEOUS

Fever	Chills	Night Sweats
Insomnia	Chronic Fatigue	Morning Tiredness
Headaches	Migraines	Concussion
Convulsions	Dizzy Spells	Shaking or Trembling
Sudden Weight Loss	Sudden Weight Gain	Balance Problems
Bleed or Bruise Easy	Heat Intolerance	Cold Intolerance
Recent Enlargement of Lymph Nodes	Sudden Energy Drop What time of day _________________	Chronic Weakness of any Part of Body
Frequent Infections	Epileptic Seizures Grand Mal Petit Mal	

PSYCHOLOGIAL HISTORY

Are you easily susceptible to stress? ____

Have you recently been emotionally upset? ____

Do you have a tendency to nervousness? ____

Do you tend to be easily irritable? ____

Are you prone to lapses of memory? ____

Have you ever had an anxiety attack? ____

Have you ever had a nervous breakdown? ____

Are you currently in therapy? ____

If so, what type? ____

Are you prone to excessive depression? ____

Are you prone to excessive fear? ____

Have you ever considered or attempted suicide? ____

Do you currently take sedatives or mood elevators? ____

Have you ever been hospitalized for emotional problems? ____

PERSONAL HABITS

Do you smoke or use tobacco products? _____________ How much per day? _________________________

Do you consume alcohol? _________________________ How much per day? _________________________

Do you drink coffee? _____________________________ How much per day? _________________________

Have you ever had a drug dependency? ____

Do you use marijuana? ____________________________ How much per day? _________________________

Do you take any other drugs for non-medical reasons? ____

Which? ____ How much per day? _________________________

Do you provide any specific time each day for relaxation, meditation, etc? _______________________________________

How much? ____

DIET AND EXERCISE

Do you have an organized or regular program of exercise or other physical activity? ________________________________

If so, please describe ____

Have you ever been on a restricted diet? (such as sugar-free, low salt, wheat restricted)

____

Please describe an example of your typical daily diet:

Morning	Afternoon	Evening

Do you take any vitamins, herbs, homeopathic remedies or other special foods or supplements? _____________________
Please list and give reasons: ____
____
____

ALLERGIES: Please list all allergies and when you first experienced them: ____
____
____
____
____

Are you allergic to any medications? ____
____
____

INJURIES: List all serious injuries and dates that they occurred. ____
____
____
____

SURGERIES Please list all surgeries and their dates.____
____
____
____

Have you been hospitalized for any other reason? Please explain: ____
____
____

FAMILY HISTORY

Is there a history of any of the following in your family?

CONDITION		FAMILY RELATIONSHIP
Tuberculosis	Yes No	
Diabetes	Yes No	
Cancer	Yes No	
Heart Trouble	Yes No	
Gout	Yes No	
Strokes	Yes No	
High Blood Pressure	Yes No	
Low Blood Pressure	Yes No	
Glaucoma	Yes No	
Asthma/ Hay Fever	Yes No	
Epilepsy	Yes No	
Allergies	Yes No	
Kidney/ Bladder Trouble	Yes No	
Anemia	Yes No	