

**PATIENT INTAKE FORM**

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Although some of the questions may seem unrelated to your condition, these details allow us to create a customized treatment plan especially for you. All your information will be confidential. Please feel free to ask if you have any questions. *Thank you.*

**Contact Information**

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Full Name \_\_\_\_\_ Date \_\_\_\_\_

Gender  Female  Male \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Marital Status  single  married  divorced  widowed \_\_\_\_\_ # of children \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Main phone# \_\_\_\_\_ Alternate phone# \_\_\_\_\_

E-mail address \_\_\_\_\_ Allow contact by e-mail?  
 Yes  No

Emergency contact name \_\_\_\_\_ phone# \_\_\_\_\_

Family physician \_\_\_\_\_ Ever tried acupuncture before?  
 Yes  No

How did you find out about our clinic? \_\_\_\_\_

**Present Health**

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Main concern \_\_\_\_\_

What diagnosis, if any, have you received for this problem \_\_\_\_\_

\_\_\_\_\_ How long have you had this problem \_\_\_\_\_

To what extent does this problem interfere with daily activities \_\_\_\_\_

What kind of treatment have you tried \_\_\_\_\_

Anyone in your immediate family with similar/same problem \_\_\_\_\_



**Circle any symptoms you have experienced in the last 3 months. Where applicable, fill in the blanks.**

**General**

Recent weight change	Fever	Night sweats	Chronic infections
General weakness	Chills	Poor sleep	Favorite season _____
Fatigue	Bruise or bleed easily	Slow wound healing	Worst season _____
Sudden energy drop	Sweat easily	Frequent colds	

**Skin, Hair, and Nails**

Dry skin	Psoriasis	Sores	Dandruff
Rashes	Acne	Warts	Hair loss
Itching	Purpura	Change in skin texture	Other _____
Hives	Change in mole size/color	Change in hair	
Eczema	Ulcerations	Change in nails	

**Head and Neck**

Headache	Glaucoma	Vertigo	Sores on lips or tongue
Migraine	Night blindness	Nasal stuffiness	Neck pain
Facial pain	Spots in front of eyes	Sinus problems	Neck stiffness
Dizziness	Eye pain	Nosebleeds	Swollen glands
Poor vision	Eye discharge	Sore throat	Goiter
Wear glasses/contacts	Hearing loss	Jaw clicks or pops	Limited range of motion - neck
Blurry vision	Ringing in ears	Grinding teeth	Other _____
Double vision	Earaches	Dental problems	
Cataracts	Ear discharge	Bleeding gums	

**Musculoskeletal**

Muscle pain/soreness	Elbow pain	Foot/ankle pain	Joint sprain
Muscle weakness	Hand/wrist pain	Decreased range of motion	Swollen joints
Back pain	Hip pain	Joint disorders	Other _____
Shoulder pain	Knee pain		

**Neurological**

Poor memory	Unsteady gait	Abnormal sensations	Paralysis
Changes in speech	Loss of balance	Numbness	Tremors
Changes in mood	Lack of coordination	Tingling	Other _____

**Cardiovascular**

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Chest pain or pressure	Irregular heartbeat	Swelling or edema	Varicose veins
Palpitations	Rapid heartbeat	Blood clots	Other _____

**Respiratory**

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Chest pain	Cough	What color? _____	Bronchitis
Shortness of breath	Coughing blood	Difficulty breathing	Pneumonia
Wheezing	Production of phlegm	Difficulty breathing at night	Other _____

**Gastrointestinal**

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Bad breath	Nausea	Hiatal hernia	<i>Bowel Movements:</i>
Cravings	Vomiting	Rectal pain	Frequency _____
Peculiar tastes	Loss of appetite	Hemorrhoids	Color _____
Acid reflux	Increase in appetite	Diarrhea	Odor _____
Difficulty swallowing	Weight loss	Constipation	<input type="checkbox"/> Hard
Increased Thirst	Weight gain	Chronic laxative use	<input type="checkbox"/> Well-formed or
Decreased Thirst	Abdominal pain/cramps	Black or tarry stools	<input type="checkbox"/> Loose
Bloating	Ulcer	Blood in stools	Other _____
Belching or Gas	Parasites	Mucus in stools	

**Urinary**

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Frequent urination	Incontinence	Cloudy urination	Urinary tract infection
Urgent urination	Burning urination	Blood in urine	Other _____
Nighttime urination	Painful urination	Kidney stones	

**Males Only**

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Reduced force of urine stream	Decreased libido	Infertility	Genital rashes
Dribbling urination	Excessive libido	Scrotal pain or swelling	Genital warts
Prostate problems	Erectile dysfunction	Penile Discharge	Genital herpes
Inguinal hernia	Premature ejaculation	Genital itching	Other _____

