Acupuncture & Massage Initial Intake Form

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Patient Name:_____
Age:_____ Birth Date:____/____/____ Sex:_____ SSN:_____-_____-_____
Address:_____
City:_____ State:_____ Zip_____
Telephone (Day):_____
Telephone (Night):_____
Telephone (Mobile):_____
Email Address:_____
Occupation:_____

Main Complaint

Please identify the major health concerns for which you are seeking help with in order severity and for how long you have had each problem.

1. _____ How long?_____
2. _____ How long?_____
3. _____ How long?_____
4. _____ How long?_____
5. _____ How long?_____

How would you rate the quality of your life (1=very poor, 10=excellent)? 1 2 3 4 5 6 7 8 9 10

To what extent do these problems interfere with your daily activities and effect your quality of life?_____
_____
_____

What are your goals in coming to our office?_____
_____

Have you been given a diagnosis for these problems? _____
_____

What other treatments have you tried and what has been your response? _____
_____

General Information

Who referred you to us? _____Phone:_____
Who is your primary heath care provider/MD? _____Phone:_____
In an emergency notify: _____Phone:_____

Personal Medical History

Illnesses:_____
_____
Surgeries:_____
_____
Significant Trauma (i.e. motor vehicle accidents, falls…)_____
_____
_____
Do you or have you ever had any infectious disease?_____. If so please describe:_____
_____

Medicines (Please list all medications, herbs, vitamins, and over the counter drugs you are currently taking):
_____
_____
_____
_____

Allergies/Sensitivities: Please list any foods, drugs, medications, or environmental factors which you are sensitive or allergic to:_____
_____
_____

Do you have allergic reactions to any oils, lotions, ointments, latex, or other substances applied to your skin? If so please describe:)_____
_____

Significant Illnesses:

- ❑ Cancer
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Thyroid Disease
- ❑ Seizures
- ❑ Rheumatic Fever
- ❑ Heart Disease
- ❑ Stroke
- ❑ Addictive Disorders
- ❑ Food Allergies
- ❑ Allergies
- ❑ Respiratory Problems
- ❑ High Blood Pressure
- ❑ HIV or AIDS
- ❑ Mental Illness
- ❑ Other: _____

Habits:	Heavy	Moderate	Light	None
Exercise	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Soft Drinks	_____	_____	_____	_____
Sugar Consumption	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Fast/Junk Food	_____	_____	_____	_____
Recreational Drugs	_____	_____	_____	_____

Family Medical History

Check All Applicable	Mother	Father	Sisters	Brothers	Spouse	Children
Current Age						
Arthritis						
Asthma						
Allergies						
Autoimmune Disease						
Back pain						
Cancer						
Constipation						
Diarrhea						
Diabetes						
Digestive Disorders						
Emotional Problems						
Epilepsy						
Headaches/Migraines						
Heart Disease						
High Blood Pressure						
Insomnia						
Kidney Disease						
Liver Disorders						
Reflux						
Stress/Anxiety						
Other						

If any of the above are deceased, what was the cause?_____
_____

Childhood health: _____
_____

General (please check all that apply)

- ❑ Poor Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Tremors
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Puffiness or Swelling
- ❑ Sudden Energy Drops
- ❑ Particular Tastes or Smells
- ❑ Fatigue
- ❑ Chills
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Other:_____

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Changes in Hair Texture
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Poor Sleep
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles
- ❑ Chills

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Toothache
- ❑ Headaches
- ❑ Night Blindness
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Glasses
- ❑ Ear Ringing
- ❑ Teeth Problems
- ❑ Concussions
- ❑ Blurry Vision
- ❑ Facial Pain
- ❑ Eye Pain
- ❑ Spots in Front of Eyes
- ❑ Decreased Hearing
- ❑ Poor Vision
- ❑ Sinus Problems
- ❑ Taste/Smell Problems
- ❑ Eye Strain
- ❑ Poor Hearing
- ❑ Jaw Click
- ❑ Color Blindness
- ❑ Recurrent Sore Throat
- ❑ Floaters

Cardiovascular

- ❑ High Blood Pressure
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Light Headedness

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Gastro-Intestinal

- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching
- ❑ Loss of Appetite

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ S.T.D.s
- ❑ Urgency to Urinate
- ❑ Frequent Urine
- ❑ Kidney Stones
- ❑ Pain in Groin Area
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Genital Sores
- ❑ Frequent Night Urination

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Bad Temper
- ❑ Poor Memory
- ❑ Irritability
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Tremors
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings
- ❑ Dizziness

Gynecology

Age of First Menses: _____
Duration of Menses: _____
Date of Last Menses_____
# of Pregnancies: _____
# of Births: _____

- ❑ Irregular Periods
- ❑ Painful Periods
- ❑ Breast Lumps
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems

Musculo-Skeletal

- ❑ Arthritis
- ❑ Muscle Weakness
- ❑ Muscle Cramping
- ❑ Muscle Spasms
- ❑ Scoliosis
- ❑ Weak Joints

Please Circle Any Areas of Pain: