

Medical Intake Form

Name _____ Date _____

Home Address _____

City _____ State _____ ZipCode _____

Home Phone _____ Work Phone _____

Best # to reach you _____ Email _____

Occupation _____ Person responsible for your account _____

Emergency Contact _____ Phone _____

Who should we thank for referring you to this office? _____

Sex: Male Female Height _____ Weight _____ Birthdate _____ Age _____

Marital Status: Single Married Divorced Widowed Number of children _____

Have you received acupuncture therapy before? Yes No

When? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative (grandparent, parent, sibling) have had:

| Illness | You | Relative | Date | Illness | You | Relative | Date |
|---------------------|-----|----------|-------|---------------------|-----|----------|-------|
| Cancer | | | _____ | Diabetes | | | _____ |
| Hepatitis | | | _____ | Heart Disease | | | _____ |
| High Blood Pressure | | | _____ | Seizures | | | _____ |
| Rheumatic Fever | | | _____ | Emotional Disorders | | | _____ |
| Infectious Diseases | | | _____ | Tuberculosis | | | _____ |

Sexually Transmitted Diseases: Gonorrhea Syphilis HIV HPV Chlamydia Herpes Date _____

List any medications & supplements you are currently taking: (continue on back if necessary)

| Medicine | Dosage | Reason | How Long | Prescribed By | Date of last checkup |
|----------|--------|--------|----------|---------------|----------------------|
| | | | | | |
| | | | | | |

Please indicate the use and frequency of the following:

| | Yes | No | Amt | | Yes | No | Amt | | Yes | No | Amt |
|-------------------|-----|----|-------|---------|-----|----|-------|--------------|-----|----|-------|
| Coffee/black tea | | | _____ | Tobacco | | | _____ | Water intake | | | _____ |
| Non-medical drugs | | | _____ | Alcohol | | | _____ | Soda pop | | | _____ |

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For Women

Age of 1st period (menarche) Are you pregnant? # of Pregnancies
Age of last period (menopause) # of Live births # of Abortions # of Miscarriages
Number of days between periods Date of last Gynecologic exam Pap smear
Number of days of flow Date last Mammogram Bone Density Scan
Color of flow Results of Exams
Clots: Yes No Color
Average # of pads used per day: 1st day 2nd day 3rd day 4th day 5th day +days
Have you been diagnosed with: Fibroids Fibrocystic breasts Endometriosis Ovarian Cysts PID Other
Location of Pain: Lower abdomen Lower back Thighs Other
Nature of Pain (indicate before, during, after menses) Other Symptoms related to Menstruation(Menses)
Cramping Stabbing Discharge Vaginal Dryness Headache
Burning Aching Nausea Constipation Diarrhea
Dull Bloating Swollen Breasts Mood Swings Ravaneous appetite
Consistent Intermittent Poor appetite Hot Flashes Night Sweats
Bearing Down sensation Increased Libido Decreased Libido Insomnia

For Men

Date of Last Prostate ck-up PSA Results Manual prostate exam results
Lab Results
Frequency of urination: Daytime Nighttime Color of urine: Clear Murky Odor
Symptoms related to Prostate: Prostate Problems Delayed Stream Dribbling
Incontinence Retention of Urine Erectile Dysfunction Increased Libido
Decreased Libido Premature Ejaculation Impotence Back pain Groin Pain
Testicular Pain Other

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SYMPTOM SURVEY (for Everyone)

The Following is a List of Symptoms that you may or may not have ever experienced. Please indicate as follows:

No mark()=never experienced Check mark ()= sometimes experience Plus sign (+)= Frequently experience

| | | | |
|-----------------------------------------------------|--------------------------------------|---------------------------------------|---------------------------------|
| Lack of appetite | Insomnia, Difficulty sleeping | Cough | Low back pain |
| Excessive appetite | Heart Palpitations | Shortness of Breath | Knee problems |
| Loose stool or Diarrhea | Cold hands & Feet | Decreased sense of smell | Hearing impairment |
| Digestive problems, Indigestion | Nightmares | Nasal problems | Ear ringing |
| Vomiting | Mentally Restless | Skin problems | Kidney stones |
| Belching, Burping | Laughing for no apparent reason | Feeling of claustrophobia | Decreased sex drive |
| Heartburn, Reflux | Chest pain, Angina | Bronchitis | Hair Loss |
| Feeling of retention of food in Stomach | Sciatic Pain | Colitis or Diverticulitis | Urinary problems |
| Tendency to become obsessive in work, relationships | Headaches | Constipation | Fatigue |
| | Pain or coldness in the genital area | Hemorrhoids | Edema |
| | | Recent use of antibiotics | Blood in stool |
| | | Eye problems | Black tarry stool |
| | | Jaundice (yellowish skin, eyes) | Easily bruised |
| | | Difficulty digesting oily foods | Difficult to stop bleeding |
| | | Gallstones | Asthma |
| | | Light colored stools | Tendency to catch colds |
| | | Soft, brittle nails | Intolerance to weather changes |
| | | Easily angered, agitated | Allergies, Hay Fever |
| | | Difficulty in making plans, decisions | Dizziness, tend to faint easily |
| | | Spasms, twitching | High cholesterol levels |
| | | | Sudden weight loss |

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What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you have?

List any allergies, food sensitivities or food cravings.

List any accidents, surgeries or hospitalizations & date:

Lab Results(please include copies):

For office use only

Clinical Notes: Onset, Location, Duration, Cx, Aggravation, Related factors, Treatment, Significance

How do you feel about the following areas of your life? Please say: **Good, Great, Fair, Poor, Bad & Explain**

Significant Other _____

Family: _____

Diet _____

Sex _____

Self _____

Work _____

Exercise _____

Spirituality _____

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