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live without pain

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Acupuncture Intake Form

Oriental Medicine often uses unusual or seemingly insignificant body changes to diagnose the cause of health problems. Some of the following questions may not appear to be related to your primary health problem, but your best answer to each question will provide us with the information we need to make a precise diagnosis.

Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

I. General Patient Information

Date: ____/____/_____ Name: _____
Address: _____
City, Province, Postal Code: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
May we contact you: ❑at home ❑at work ❑email (provide address) _____
Date of Birth: ____/____/____ Place of Birth: _____
Gender: ❑M ❑F Marital Status: ❑Married ❑Single Height: ____'____" Weight: _____lbs
Occupation: _____ Employer: _____
Hours worked per week _____ Is your health complaint related to work? ❑Yes ❑No ❑Maybe
How did you hear about our office? _____
Guardian (if under 18): _____
Person to notify in case of emergency _____ Phone Number: (_____) _____
Major Complaint(s), in order of significance to you:
1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional: _____
How do these conditions impair your daily activities? _____
_____

II. Patient Medical History

How was your childhood health? _____
HospitalVisits/Stays: _____
Recent tests: (please indicate test results and date below)
❑Physical ❑Cholesterol ❑Prostate ❑Blood (which?) ❑HIV/STD ❑Pap smear ❑Mammography
Test Results and Date: _____
Check any you have had in the past:

❑Diabetes	❑Asthma	❑Syphilis	❑Epilepsy	❑Other lung illnesses
❑Allergies	❑Pneumonia	❑Measles	❑High fever	❑Other liver illnesses
❑Glaucoma	❑Tuberculosis	❑Chicken pox	❑Hepatitis	❑Other heart illnesses
❑Rheumatic Fever	❑Emphysema	❑Nervous disorder	❑Multiple Sclerosis	❑Other kidney illnesses
❑Heart Disease	❑Jaundice	❑Meningitis	❑Paralysis	❑Vasectomy
❑CVA (stroke)	❑Gonorrhea	❑HIV	❑Cancer	❑Sleep Apnea
❑Vein condition	❑Mumps	❑Polio	❑Migraines	❑Shingles
❑Thyroid disorder	❑Bleeding tendency	❑Mononucleosis	❑High blood pressure	❑Anemia

Other: _____
Surgeries: _____
Serious injuries or accidents: _____

III. Patient Profile
Is the pain:
❑Sharp ❑Burning ❑Aching
❑Cramping ❑Dull
❑Moving ❑Fixed
❑Other: _____
Do the following lessen the pain?
❑Pressure ❑Cold ❑Heat
❑ Exercise
❑Other: _____
Do the following worsen the pain?
❑Pressure ❑Cold ❑Heat
❑Other: _____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function).

Overall Energy
❑Low energy ❑General weakness
❑Easily catch colds
❑Difficulty keeping eyes open in the daytime
❑Feel worse after exercise
❑Overall achy feeling in the body
❑Low libido ❑Excessive libido
❑General sensation of heaviness in the body ❑Mental heaviness
❑Mental fogginess ❑Dizziness
❑Swollen joints, where? _____
❑Edema, where? _____
❑Skin is often damp or moist

Overall Temperature (Kidney function)
❑Cold body temperature (more sensitive to cold than the average person)
❑Cold sensation in the knees
❑Can get chilled to the bone (hard to get warm again)
❑Afternoon flushes ❑Night sweats
❑Heat in the hands, feet, and chest
❑Hot flashes any time of the day or night

Eyes, Ears, Nose, Throat
❑Headaches ❑Migraines
❑Seasonal Allergies
❑Continuous Allergies (dust, etc)
❑Sinus congestion
❑Nasal discharge ❑Sneezing
Dry: ❑lips ❑mouth
❑nose ❑throat
Eyes: ❑Itchy ❑Bloodshot
❑Dry ❑Watery ❑Gritty
❑See floating black spots
❑Decreased night vision

Heart & Circulation function:
❑Mental confusion
❑Chest pain
❑Chest pain traveling to shoulder
❑Drink coffee
# of cups per week: ___
❑Difficulty falling asleep
❑Difficulty staying asleep
❑Nightmares
❑Wake unrefreshed

Lung function:
❑Difficulty breathing
❑Shortness of breath ❑Cough
❑Chest congestion
❑Asthma: ❑ongoing ❑in the past

Digestive Power / Stomach function:
❑Low appetite
❑Excessive appetite
❑Abrupt weight gain
❑Abrupt weight loss
❑Fatigue after eating
❑Easily bruised ❑Hemorrhoids
❑Over-thinking ❑Worry
❑Nose Bleeds
❑Other bleeding issues (describe) _____
❑Prolapsed organs previously diagnosed, which organs? _____

Large Intestine, Small Intestine function:
❑Loose stools ❑Constipated
❑Diarrhea ❑Incomplete BM (Bowel Movement)
❑Alternating diarrhea and constipation
❑Feel worse before BM ❑Feel better before BM
❑Hot body temperature (sensation)
❑Alternating fevers and chills
❑Take water to bed
❑Excessive Thirst
❑Easily Perspire
❑Excessive Perspiration
❑Rarely Perspire...
❑even when exercising
❑Graying Hair ❑Anxiety
❑Restlessness ❑Palpitations
❑Chest tightness
❑Sores on the tip of the tongue
❑Pain radiating down the arm
❑Varicose Veins, where? _____
❑Spider Veins, where? _____
❑Smoke cigarettes
# of cigarettes per day: ___
❑Chew tobacco ❑Sadness
❑Melancholy ❑Dry Skin
❑Cracks in hands or feet
❑Sleep Apnea ❑Acid reflux
❑Heart burn ❑Mouth sores
❑Bad breath ❑Stomach Pain
❑Nausea ❑Vomiting
❑Abdominal bloating ❑Belching
❑Passing gas ❑Hiccoughs
❑Gurgling noise in the stomach
❑Ulcer (diagnosed)
❑Burning sensation after eating
❑Feel better after eating
❑Feel better before eating
❑Blood in stools
❑Mucous in stools
❑Undigested food in stools
❑Frequent BM # per day__
❑High pitched ringing in ears
❑Low pitched ringing in ears
❑Ear aches ❑Mouth sores
❑Tongue sores ❑Bad breath
❑Bleeding, swollen, painful gums
❑Sore throat ❑Phlegm in throat
❑Difficulty Swallowing
❑Jaw Pain (TMJ)

Liver, Gall Bladder function:
❑Anger easily ❑Frustration
❑Depression ❑Irritability
❑Pain in the ribs
❑Tightness in the chest
❑Bitter taste in the mouth
❑Tingling sensation ❑Numbness
❑Weak fingernails
Muscle: ❑spasms ❑twitching
❑cramping
❑Recreational drugs
Which?_____
How much per week? _____

Kidney, Urinary Bladder function:
❑Frequent cavities, other dental problems (past or present)
❑Easily broken bones
❑Weakness in low back
❑Memory problems
❑Excessive hair loss
Urination: ❑Dark yellow (often)
❑Reddish ❑Blood in Urine
❑Cloudy ❑Scanty ❑Profuse
❑Interrupted ❑Weak Stream
❑Sexually transmitted disease
Which?_____

Muscle/Skeletal
❑Neck tension ❑Pain
❑Limited Range-of-Motion in neck
❑Shoulder tension ❑Pain
❑Limited Range-of-Motion in shoulder
❑Upper back tension ❑Pain
❑Muscle weakness
Where? _____

Women only:
❑Irregular menstrual cycle
For ___ # of years ___ # of months
❑Regular menstrual cycle?
Pregnant? ❑Yes ❑No
Number of children:____
Number of pregnancies:____
Age of first menstruation:____
Age of menopause (if applicable):____
Average number of days of flow:_____
Average number of days of entire cycle: ____to ____
❑Severe Menstrual cramps
❑Bleeding between periods
❑Mild Menstrual cramps
❑Unusual vaginal discharges (describe)_____
Do you experience any of the following pre-menstrual syndromes (PMS)?
How many days before period does the PMS usually start? _____days.
❑nausea ❑vomiting
❑water retention ❑breast swelling
❑food cravings ❑headaches
❑migraines ❑breast tenderness
❑depression ❑irritability ❑anxiety
❑other emotions:_____
❑dull pain, where? _____
❑sharp pain, where?_____
❑Gall stones
(❑history or ❑current)
❑Seizures ❑Convulsions
❑Skin rashes, where?_____
❑Drink alcohol
❑Headache at the side(s) of the head
❑PMS symptoms (more detail below) ❑Restless Leg Syndrome
❑Exposure to toxicity
❑Cold Hands ❑ Cold Feet
❑Kidney stones
❑Wake during the night twice or more to urinate
❑Lack of bladder control ❑Fear
❑Easily startled
❑Burning ❑Painful ❑Difficult
❑Urgent ❑Frequent ❑Strong odor
❑Discharge ❑Bladder infections
❑Painful knees ❑Weak knees
❑Low back pain ❑Hip pain
❑Pain radiating down leg
❑Pain in Hands ❑Pain in Feet

Men only:
❑Swollen testes
❑Testicular pain ❑Impotence
❑Premature ejaculation
❑Feeling of coldness or numbness in external genitalia
❑Other _____
❑Erectile Dysfunction (ED)
❑Vasectomy
❑Unusual discharges from the penis

Life Style Choices:
❑Drink caffeinated beverages, # per day ___
❑Drink or use artificial sweeteners
Exercise: ❑mild
❑moderate ❑vigorous
# of hours of exercise per week___
Diet: ❑vegetarian ❑vegan
Foods that are avoided or excluded
_____

Medications
Please check the box if taken and list specific medications if possible.
❑Antacids ❑Antibiotics
❑Aspirin ❑Birth Control Pills
❑Blood Thinning Pills ❑Cortisone
❑Cough Medicine ❑Digitalis
❑Hormones
❑Insulin, Diabetic Pills ❑Iron
❑Laxatives ❑Pain Med.
❑Sleeping pills
❑Blood Pressure Med.
❑Tranquilizers ❑Vitamins
❑Water Pills
❑Weight Reduction Pills
❑Thyroid Med.
Other medications (if you have a written list please give it to the receptionist to be copied)
_____
_____
_____

Comments: _____
_____
_____

Patient Signature:
_____

SPECIAL CONSENT FOR CLINICAL PROCEDURE

I hereby request and authorize _____ to perform, during my participation in treatment, the following procedures:

Acupuncture Procedures: induced by the insertion of special disposable needles through the skin into the underlying tissues of certain indicated points on the surface of the body.

Traditional Chinese Medicine: which, in addition to acupuncture, may include, Tui Na, moxibustion, topical herbal applications, cupping, and nutrition.

Back Care Procedures: which may include massage, Tui Na, and/or specific remedial exercises.

I have had an opportunity to discuss the nature, consequences, and potential risks and benefits of the above procedures with the above named practitioner and acknowledge reading the following:

Potential risks of listed therapies may include, but are not limited to: discomfort at the site of insertion of the needles; infection, pain and discomfort, weakness, fainting, nausea, burns, and even mild aggravation of symptoms existing prior to treatment.
Potential Benefits: treatment may allow for painless and drugless relief of my presenting symptoms and improved balance of bodily energies and physical structures, which may lead to preventing further progression or elimination of the presenting problem.
With this knowledge, and the knowledge that the term 'practitioner' does not mean medical doctor, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the above mentioned practitioner regarding cure or improvement of my condition because of the performance of any of the above mentioned procedures.
In addition, the practitioner will agree to 100% confidentiality and are only to share personal patient information with the consent of the patient him/herself. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
Print Patient's Name Signature of Patient (or Parent/Guardian)

_____ _____
Signature of Practitioner Date Signed

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