

Acupuncture and Traditional Chinese Medicine Initial Intake

The following information is used to help determine how to best treat your health issues.
Please complete to the best of your abilities.

Personal Information:

Name: _____
Street Address: _____
City/Province: _____
Postal Code: _____

Occupation: _____
Phone: hm: _____ wk: _____
cell: _____

Email: _____

Sex: Male: _____ Female: _____
Date of Birth: _____ Age: _____

Physician Information:

Name: _____
Phone: _____

Emergency Contact:

Name: _____
Phone: _____

Referral Information:

Who referred you? _____

Health Concerns: Please list the concerns you have about your health today.

Conditions: Please check conditions you currently have with a C or have had in the past year with a P.

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Gallbladder Problem | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> German Measles | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Intestinal Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Lupus | <input type="checkbox"/> Vaginal Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Menstrual Disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fatigue Problem | <input type="checkbox"/> Mononucleosis | |

Family History: Check if your blood relations have had any of the following:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |

Symptoms: Mark symptoms you currently have with a C or have had in the past year with a P.
Please note quality of symptoms.

General

- Fatigue
- Insomnia
- Disturbed sleep
- Frequent dreams
- Excessive sleep
- Dislike cold
- Dislike heat
- Weight loss
- Weight gain
- Fever
- Chills
- Alternating chills and fever
- Night sweats
- Unusual daytime sweating
- Usually thirsty
- Seldom thirsty
- Edema or swelling
- Other: _____

Skin

- Rashes
- Hives
- Dry skin
- Acne
- Easily bruised
- Changes in lumps or moles
- Unusual bleeding
- Other _____

Head and Neck:

- Headaches (note type and location of pain)
- Dizziness
- Jaw pain
- Other _____

Eyes and Ears:

- Failing vision
- Blurred vision
- Visual spots
- Night blindness
- Eye pain/swelling
- Ringing in the ears
- Decreased hearing
- Ear pain
- Ear discharge
- Other _____

Nose/Throat/Mouth:

- Nose bleeds
- Nasal discharge/infection
- Frequent sneezing
- Change in sense of smell
- Sore throat
- Hoarseness

Nose/ Throat/ Mouth cont'd:

- Difficulty in swallowing
- Change in sense of taste
- Tooth or gum pain
- Bleeding gums
- Mouth or tongue ulcers
- Other _____

Muscles and Joints:

Pain, weakness or numbness in:

- Neck/Shoulder/ Arm/Hand
- Hips/Leg/Feet
- Sore low back and knees
- Muscle cramps
- Body pain
- Heavy limbs
- Swollen joints
- Hot joints

Nervous System:

- Fainting
- Paralysis
- Tremors
- Poor balance
- Seizures
- Other _____

Heart, Lungs and Chest:

- Palpitations
- Chest pain
- Tightness
- Rapid heart beat
- Irregular heart beat
- Swelling of the ankles
- Cough
- Dry Cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Asthma/ wheezing
- Frequent colds
- Pain in rib cage
- Other _____

Mental/Emotional:

- Difficulty concentrating
- Poor memory
- Worry
- Anxiety
- Depression
- Irritability
- Frustration or anger
- Fearfulness
- Stress
- Other _____

Digestive System:

- Nausea
- Vomiting food
- Vomiting blood
- Diarrhea
- Constipation
- Loose stools
- Bloody/black stools
- Stomach pain
- Abdominal pain
- Poor appetite
- Excessive hunger
- Abdominal bloating/gas
- Belching
- Indigestion
- Acid reflux
- Hemorrhoids

Urinary/Genital:

- Painful urination
- Difficult urination
- Frequent daytime urination
- Frequent nighttime urination
- Incontinence
- Cloudy urine
- Bloody urine
- Genital pain or itch
- Genital discharge or lesions
- Painful intercourse
- Low sexual drive
- Excessive sexual drive
- Other _____

Male:

- Impotence
- Weak urinary stream
- Prostate hypertrophy
- Premature ejaculation
- Seminal emissions

Female:

- Irregular periods
- Painful periods
- Bleeding between periods
- Passing clots
- Scanty periods
- Early periods
- No periods
- PMS
- Menopausal symptoms
- Abnormal PAP smear
- Breast lump
- Breast pain or discharge
- Vaginal discharge
- Other _____

Women Only: Please answer the following questions if applicable to you.

Menstrual Cycle: Describe your typical period.

How many days are there between your periods? _____ Date of last menstrual period: _____

How many days does your period last? _____

Quality of Blood:

- Light red
- Bright red
- Dark Red
- Clotted
- Other (please describe) _____

If you are in menopause, please describe the age of onset and the past and current symptoms you experience(d).

Pregnancy and Birthing History

Are you currently pregnant?

- Yes
- No

Are you trying to become pregnant?

- Yes
- No

If you use birth control, please note what method you use and how long you have been using this method.

Date of last Pap smear: _____

Please note the number of pregnancies you have had, the number of deliveries you have had and any relevant information – i.e. heavy bleeding with delivery, problem free delivery etc.

Patient Signature: _____

Date Signed: _____
(month) (day) (year)