ACUPUNCTURE FIT

PATIENT INTAKE FORM

Name _____ Date _____

Date of Birth _____ Gender: ☐ Male ☐ Female

NOW: ☐ **PREGNANT** ☐ **PACEMAKER** ☐ **HIV DISEASE** ☐ **HEPATITIS** ☐ **BLOOD TRANSFUSION**

FAMILY HISTORY:

☐ Abuse ☐ Allergies ☐ Chemical Dependency ☐ Heart Disease ☐ Mental Illness ☐ Seizures
☐ AIDS ☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Respiratory Diseases ☐ Stroke
☐ Alcoholism ☐ Cancer ☐ Other:

YOUR PAST MEDICAL HISTORY/ILLNESSES: ☐ Other:_____

☐ Aids/HIV ☐ Bi Polar ☐ Colitis ☐ Heart Disease ☐ Low blood pressure ☐ Parkinson's ☐ Substance Abuse/Addiction
☐ Alcoholism ☐ Bronchitis ☐ Cough (Whooping) ☐ Hepatitis ☐ Migraine ☐ Pneumonia ☐ Suicide attempt
☐ Allergies ☐ Cancer ☐ Diabetes ☐ Hernia ☐ Mononucleosis ☐ Prostate issues ☐ Thyroid Disease
☐ Anemia ☐ Candida (Yeast) ☐ Eating Disorder ☐ Herniated disc ☐ Multiple Sclerosis ☐ Rheumatic Fever ☐ Tuberculosis
☐ Arthritis ☐ Chemical Dependency ☐ Fracture ☐ High Blood Pressure ☐ Mental Illness ☐ Seizures ☐ Ulcers
☐ Asthma ☐ Chronic Fatigue Syndrome ☐ Glaucoma ☐ High Cholesterol ☐ Osteoporosis ☐ Epilepsy ☐ Vaccine Reaction
☐ Auto Immune Disease ☐ Chronic Lung Disease ☐ Gall Stones ☐ Kidney Disease ☐ Organ Transplant ☐ Sexually Transmitted Diseases (STD)
☐ Bleeding Disease ☐ Gout ☐ Liver Disease ☐ Stroke
☐ Breast Cysts ☐ Headaches

SURGERIES: (Please include dates and if any complications)

1 -_____ 2_____
3- _____ 4_____

TRAUMATIC INJURY: (Please include dates and if any complications)

Car accident(s) _____
Fall(s) _____
Other _____

ALLERGIES / ALERGIAS

Drugs/Medication _____
Chemicals _____ _____
Food _____ Seasonal/Environmental _____

CURRENT MEDICATIONS:
OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:

Chemical: _____ Acid/Alkalines: _____
Heavy Metals: _____ Physical Labor: _____
Electrical: _____ Psychological: _____

HABITS/EXCESSIVE USAGE: (Please tell us how often & how much)

☐ alcohol_____ ☐ coffee _____ ☐ food_____ ☐ salt _____
☐ artificial sweetener _____ ☐ cola_____ ☐ sex _____ ☐ sugar _____
☐ chocolate_____ ☐ drugs _____ ☐ tea _____ ☐ water _____
☐ cigarettes _____ ☐ exercise_____ ☐ other _____

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CHIEF COMPLAINT / REASON FOR YOUR VISIT:_____

How and when did this condition begin?_____

_____

Please list your main health concerns you would like to be free of, in order of importance:

1. _____ **2.**_____

3._____**4.** _____

GENERAL (Please check all that apply to you within the last 3 months)

☐ poor appetite	☐ insomnia	☐ bleeds easily	☐ diff loosing/gaining weight
☐ change in appetite	☐ hours of sleep _____	☐ bruises easily	☐ excessive need for sleep
☐ large appetite	☐ easy to fall asleep	☐ chronic fatigue	☐ chills
☐ cravings	☐ heavy sleeper	☐ lethargy	☐ trouble falling asleep
☐ weight gain	☐ light sleeper	☐ fatigue/tired	☐ hot flashes
☐ weight loss	☐ disturbing dreams	☐ sudden drop in energy	☐ tremors/shaking
☐ sleep walking	☐ trouble staying asleep	☐ vertigo	☐ edema
☐ weakness	☐ sleep apnea	☐ bitter taste	☐ poor coordination
☐ fevers	☐ dizziness	☐ headache	☐ Herbs
☐ sweating	☐ Vitamins	☐ mental fog	☐ Supplements

Energy level: ☐ high ☐ moderate ☐ low ***Thirst desires***: ☐ hot ☐ cold ☐ room temp. ☐ no desire
Cold sensations: ☐ hands ☐ feet ☐ back ***Heat sensations***: ☐ hands ☐ feet ☐ solar plexus ☐ abdomen ☐ whole body
Stiffness: ☐ joints ☐ back ☐ limbs ***Intolerance to***: ☐ hot ☐ cold ☐ wind ☐ fan ☐ A/C
Work odd hours: _____ ***Do you make time for relaxation/meditation/prayer?*** ☐ yes ☐ no
Are you taking: ☐ Aspirin ☐ Blood Thinners
Do you follow a special diet: ☐ yes ☐ no
If so, please explain: _____

SKIN AND HAIR (Please check all that apply to you within the last 3 months)
PIEL Y PELO (indique todo lo que le apliqué en los ultimos 3 meses)

☐ rashes	☐ eruptions	☐ change in skin texture	☐ fungal/yeast infection
☐ eczema	☐ discharge	☐ dandruff	***skin type***: ☐ dry ☐ moist
☐ sores	☐ pimples/acne	☐ loss of body hair	☐ other skin problems: _____
☐ ulcers	☐ bruises	☐ change in hair	☐ other hair problems: _____
☐ herpes	☐ itching	☐ balding	
☐ psoriasis	☐ hives	☐ thinning of hair	

HEAD, EYES, EARS, NOSE, MOUTH & THROAT(Please check all that apply within the last 3 months)

Head	**Eyes (R/L)**	**Ears (R/L)**	**Nose**	**Mouth**	**Throat**
☐ dizziness	☐ cataract/	☐ loss of hearing	☐ loss of smell	☐ grind teeth	☐ dry throat
☐ migraine	☐ glaucoma	☐ discharge	☐ good sense of smell	☐ drooling	☐ hoarseness
Headaches:	☐ eye pain	☐ earaches	☐ nose bleeds	☐ excess saliva	☐ recurrent
☐ frontal	☐ twitching	☐ poor hearing	☐ allergies	☐ dry mouth	☐ sore throat
☐ temporal	☐ floaters/spots	☐ itchiness	☐ nasal discharge	☐ gum disease	☐ loss of voice
☐ vertex	☐ poor vision	***Ringing in ears***:	***color***: ☐ yellow	☐ bad breath	☐ difficulty
☐ occipital	☐ blurry vision	☐ loud ☐ soft	☐ white ☐ clear	☐ gum bleeding	☐ swallowing
☐ head injury	☐ night blindness	☐ high pitch	☐ green	☐ gum swelling	☐ "lump in throat"
☐ facial pain	☐ itchiness	☐ low pitch	***amount***:	☐ scanty	☐ frequent
☐ facial paralysis	☐ glasses/contacts	☐ inflammation	☐ mod	☐ heavy ☐ ulcers	☐ tonsillitis
☐ sinus problems	☐ red eyes	☐ tenderness	☐ thick	☐ thin ☐ sores	☐ freq. sore throat
☐ heaviness in head			☐ dry nose	☐ dry lips ☐ taste in mouth	

other _____

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CARDIOVASCULAR (Please check all that apply to you within the last 3 months)

☐ high blood pressure ☐ chest pain ☐ difficulty in breathing ☐ coma
☐ low blood pressure ☐ cold hands/feet ☐ shortness of breath ☐ loss of consciousness
☐ dizziness ☐ swelling hands/feet ☐ dream disturbance ☐ heart pounding
☐ fainting ☐ irregular heart beat ☐ poor memory ☐ stifling sensation in chest
☐ palpitations ☐ insomnia ☐ mania/delirium other:_____

RESPIRATORY (Please check all that apply to you within the last 3 months)

☐ pneumonia ***cough***: how long? _____ ☐ shortness of breath
☐ bronchitis ☐ dry ☐ croup ☐ rapid ☐ other ☐ fullness in chest
☐ asthma ***phlegm***: ☐ thin ☐ thick ☐ clear ***difficulty breathing***:
☐ coughing blood ☐ white ☐ yellow ☐ green ☐ sitting ☐ lying down
☐ wheezing ☐ tightness in chest ☐ allergies ☐ difficulty inhaling or exhaling
☐ frequent colds ☐ sinus infection ☐ post nasal drip ☐ frequent sighing
☐ chronic cough ☐ sinus congestion ☐ heaviness in chest ☐ other chest discomfort

GASTROINTESTINAL (Please check all that apply to you within the last 3 months)

☐ food allergies ☐ taste in mouth ☐ loose stools ☐ difficult stools ☐ tenderness in abdomen
☐ vomiting ☐ belching ☐ bloody/black stools ☐ mucus in stools ☐ fullness in abdomen
☐ cramping ☐ bad breath ☐ ulcers ☐ hemorrhoids ☐ burning in abdomen
☐ gas after meals ☐ hiccup ☐ increased appetite ☐ hernia ☐ like/dislike pressure
☐ abd/stomach pain ☐ constipation ☐ poor appetite ☐ rectal pain ☐ like/dislike cold
☐ nausea ☐ diarrhea ☐ hungry-no desire to eat ☐ rectal bleeding ☐ like/dislike warmth
☐ overeat ☐ mouth sores ☐ dry, hard stools ☐ pain with passing stool ☐ difficulty swallowing
☐ tastelessness ☐ heart burn/reflux ☐ "nervous stomach" ☐ flucttion ls
☐ fatigue after eating ☐ bulimia ☐ cravings ☐ gall stones

GENITO-URINARY (Please check all that apply to you within the last 3 months)

☐ burning /painful urine ☐ poor stream/scanty urine ☐ diminished sex drive ☐ discharge
color: ☐ cloudy ☐ pale ☐ dribbling urine ☐ increased sex drive ☐ history of kidney stones
☐ dk yellow ☐ pink/red ☐ unable to urinate ☐ impotency ☐ history of bladder infections
☐ unable to hold urine ☐ frequent urination ☐ genital itching ☐ history of prostate problems
☐ urgency to urinate ☐ sexually active ? ☐ genital sores/pain ☐ history of STD
☐ wakes up to urinate more than once per night How many times?_____

NEUROPHYSIOLOGICAL (Please check all that apply to you within the last 3 months)

☐ history of mental illness ☐ melancholy ☐ joyful ☐ tremors/shaking
☐ depression ☐ grieving ☐ giddy ☐ convulsions
☐ anxiety ☐ easy to anger ☐ over-thinking ☐ coma
☐ easily stressed ☐ irritability ☐ talkative ☐ concussion
☐ confusion/foggy ☐ restlessness ☐ silent ☐ paralysis
☐ lack of clarity ☐ emotional ☐ extrovert ☐ trauma at birth
☐ moody ☐ frequent sighing ☐ introvert ☐ vaginal delivery ☐ cesarean
☐ fear/fright ☐ over-worried ☐ poor memory ☐ considered/attempted suicide
☐ hyper ☐ bad-tempered ☐ seizures ☐ unable to focus
☐ sadness ☐ tics ☐ panic ☐ phobia
☐ frustration ☐ hopelessness ☐ feeling stuck ☐ seeing therapist

MEN'S HEALTH (Please check all that apply to you within the last 3 months)

☐ prostate problems ☐ swellings, lumps and pain in testicles ☐ discharge from penis
☐ decreased libido ☐ cold feeling in genitals ☐ difficult achieving and maintaining erection
☐ hernia ☐ difficult ejaculation ☐ injury to reproductive organs
☐ infertility ☐ painful erections ☐ currently sexually active
☐ history of STD ☐ other:_____

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MUSCULO-SKELETAL (Please check all that apply to you within the last 3 months)

Area:: ☐ face ☐ jaw ☐ chest ☐ epigastric area ☐ rib cage ☐ low abdominal ☐ pelvic ☐ genitals ☐ neck ☐ shoulder ☐ fingers ☐ upper back ☐ mid back ☐ knee ☐ lower back ☐ sacrum/tailbone ☐ sciatica ☐ upper limbs ☐ lower limbs ☐ feet ☐ whole body ☐ bone ☐ muscle ☐ joint

Rate the pain: Scale 1-10 (10 worst) 1 2 3 4 5 6 7 8 9 10

Please indicate which side is affected: _____

How often is the pain present ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% of the time

Do you often carry heavy objects? ☐ not often ☐ often

Is/does your pain ***:*** ☐ fixed ☐ moves around ☐ radiates ☐ sharp ☐ dull

Is the pain ☐ ***aggravated by*** ☐ ***alleviated by:*** ☐ sitting ☐ standing ☐ movement ☐ pressure ☐ warmth ☐ cold ☐ other:_____

Do you have? ☐ pain ☐ swelling ☐ burning ☐ weakness ☐ numbness ☐ tingling ☐ arthritis ☐ clicking ☐ stiffness ☐ spasms ☐ twitching ☐ shaking ☐ soreness ☐ tenderness ☐ unsteadiness ☐ tension ☐ heaviness ☐ better with movement ☐ worse with movement ☐ hernia

GYNECOLOGY AND PREGNANCY (Please check all that apply to you within the last 3 months)

Date of last PAP:_____ Last Menstrual Period:_____

color**:** ☐ pale red ☐ light red ☐ red ☐ dark red ☐ red/purple ☐ purple ☐ dk purple ☐ brown

☐ pelvic pain ☐ currently sexually active ☐ pregnant currently ☐ # of pregnancies _____ ☐ # of live births _____

☐ no. of miscarriages _____ ☐ # of abortions_____ ☐ # of premature birth _____ ☐ age at first menses

☐ fibroids ☐ endometriosis ☐ length of period_____ ☐ abd. Bloating/fullness ☐ spotting between periods

clots: ☐ large ☐ small ☐ early menstrual cycle(less 21 days) ☐ mood change before period ☐ body change before period

☐ late menstrual cycle (less than 35 days) ***Menstrual pain/cramps***: ☐ before ☐ during ☐ after

Vaginal discharge: ☐ odor ☐ no odor ☐ watery ☐ thick ☐ curdy ☐ itchy ***color***: ☐ clear ☐ white ☐ yellow ☐ bloody

☐ infertility ☐ pain during intercourse ☐ irregular menstrual cycle ☐ days of heavy flow _____ ☐ uterine prolapsed

☐ ***menopause***: ☐ pre ☐ post ☐ endometriosis

birth control pills:
type _____
how long? _____

☐ age at menopause _____
☐ history of ovarian cysts
☐ history of uterine problems
☐ hormone replacement

flow: ☐ thick ☐ thin
amount: ☐ scanty ☐ mod ☐ heavy ☐ very heavy
☐ decreased libido

☐ vaginal burning/itching
☐ vaginal pain
☐ genital eruptions
☐ absent menstruation

BREAST (Please check all that apply to you within the last 3 months)

☐ history of breast disease
☐ breast lumps/masses
☐ history of breast cancer

☐ breast tenderness
☐ breast fullness/swelling
☐ breast pain

breast discharge: ☐ clear ☐ white ☐ yellow ☐ green ☐ black ☐ blood ☐ watery ☐ thin ☐ thick
other:_____

INFERTILITY (Please explain with as much detail as possible)

How long have you been trying to get pregnant? _____

Have you tried any method of assisted reproduction?_____

Any long term exposure to chemicals? _____

Do you keep track of you menstrual cycle? _____

Do you keep your BBT(Basal Body Temperature? _____

Do you test yourself for ovulation?_____

Has your partner been evaluated for infertility?_____

Anything else you would like to tell us?_____

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ACUPUNCTURE FIT
PATIENT DEMOGRAPHIC FORM

Date: _____

Last Name _____ First Name: _____ MI_____

Date of Birth:_____ Sex: _____ Social Security # _____

Age: _____ Marital Status: _____ Employment Status:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

Preferred Phone: ☐ Home ☐ Work ☐ Cell e-mail: _____

Please check *one* of the following:

☐ **It is permissible to call and/or leave a detailed message.**

☐ **DO NOT CALL**

Employer name: _____ Occupation/Title: _____

Employer Address _____ City _____ State_____ Zip_____

Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Address _____ City _____ State_____ Zip_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

Name _____ Telephone Number _____

Name _____ Telephone Number _____

☐ I do wish to have this information disclosed.

How were you referred to the Clinic? _____

It is the responsibility of the patient to notify the Acupuncture Fit if any of their information should change. Please inform the front desk of any changes, so that we may update your records.

_____ _____

PRINT Patient Name DATE

_____

Patient Signature

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