Acupuncture Works

Acupuncture Full Intake Form

Patient Name:_____Date:_____
Address: _____ City:_____State:____ Zip:_____
Phone- Home:_____Cell:_____
*Please circle your preferred number for us to contact you at
Date of Birth:_____Age:_____ Email:_____
Marital status:__M__S__W__D Occupation:_____
Emergency Contact:_____ Phone:_____
Physician's Name:_____ Phone: _____
Height:_____ Weight:_____ Allergies (To medications):_____
Medications currently taking: _____

Insurance Carrier:_____ ID#:_____
Group number:_____Telephone number: _____
Insured's Name:_____ Relationship to insured:_____

If self-pay disregard below*

Insured's Name:_____ Insured's Date of Birth:_____
Insured's Address:_____
Insured's SS#:_____ ID#:_____
Insured's Phone:_____ Insured's Gender: Male Female

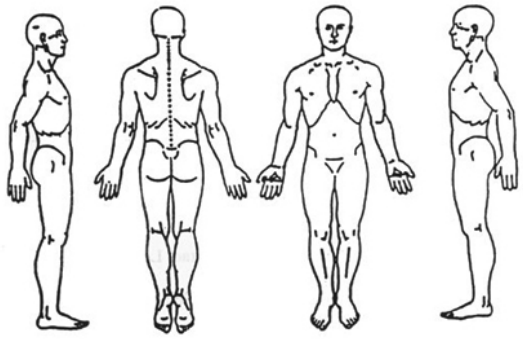
Will medical records need to be released to attorneys? Yes No

What is the problem that brought you here today?_____
WHAT IS THE PHYSICIANS DIAGNOSIS?
_____
When did the problem first appear?_____
What was the initial cause? _____
What makes it worse?_____What makes it better?_____
How does this problem interfere with your daily activities? (please circle all that apply)

Work	Sleep	Walking
Sitting	Standing	Emotional
Relationships	Social Life	Sexually
Recreation	Bending	Stretching
Other _____		

What have you done about this? _____
What are your health goals?_____
List any past or future surgeries: _____
List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, ect.)
_____
_____

Pain
Use the diagram and pain key below to indicate areas and types of pain



Pain Key

Ache
^ ^ ^ ^

Numbness
= = = =

Pins & Needles
0 0 0 0

Burning
X X X X

Stabbing
/ / / /

Use the chart below to indicate pain intensity and limitations *(please circle selection)*

Pain intensity levels

No pain	Moderate Pain	Severe pain	Terrible Pain

Sleeping

No problem	Disturbed	Very disturbed	Cannot sleep

Work- Can do:

Usual Work	50% of Work	25% of Work	No Work

Recreation- Can do:

All activities	Some activities	No activities

Travel

No problem	Moderate pain on trips	Severe pain

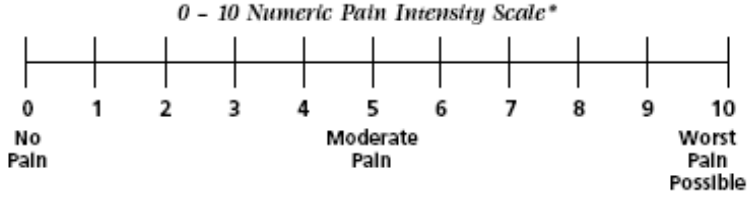
Walking

Can walk fine	Pain after ½ mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit

Circle number on pain scale below



General Health *(please circle all that apply):*

Poor Appetite Disturbed Sleep Insomnia Fatigue Poor Coordination Weight Gain Cold Hands and Feet Night Sweats Cold Abdomen Tremors Large Appetite Localized Weakness Strong Thirst Weight Loss Fevers Poor Balance Bruise/ Bleed Easily Sweat Easily Cravings (explain) _____ Chills Sudden Energy Drop Soft/ Brittle Nails Catch Colds Easily Other (please specify):_____

SYMPTOMS: Check symptoms you currently have or have had in the past years

EYE, EAR, NOSE, THROAT

__ Eye Pain/Strain
__ Dry Eye
__ Excess Tearing
__ Blood Shot
__ Double Vision
__ Dizziness
__ Fainting
__ Blurred Vision
__ Crossed Eyes
__ Floaters/Flashes
__ Eye Trauma
__ Glasses/Poor Vision
__ Night Blindness
__ Blind Field of Vision
__ Discharge From Eyes

__ Ear Discharge
__ Ringing in Ears
__ Ear Pain
__ Hearing Loss
__ Ear Infection
__ Excess Wax

__Nose Bleeds
__ Sinus Problems
__ Hay Fever
__ Food Sensitivities
__ Runny Nose
__ Sinus Infection
__ Congestion
__ Allergies

__Sore Throat-Recurrent?
__ Dry Throat
__ Hoarseness
__ Persistent Cough
__ Bleeding Gums
__ Loose Teeth
__ Swollen Tonsils/Discharge
__ Swollen Lymph Nodes
__ Difficulty Swallowing
__ Chills __Fever
__ Shortness of Breath
__ Scores on Lips or Tongue

Other:_____

HEAD

__ Migraine
__ Clicking Jaw
__ Loss of Balance

__ Headache
__ Concussion
__ Vertigo

__ Facial Pain
__ Head Hair Loss
__ Foggy Feeling

__ Grinding Teeth
__ Seizures/Ticks/Palsy

Other:_____

SKIN

__ Dry Skin
__ Acne
__ Bruise Easily
__ Hair Loss
__ Ulcerations

__ Itchy Skin
__ Sensitive Skin
__ Change in Moles
__ Hot Flashes

__ Eczema
__ Dandruff
__ Scars
__ Red Cheeks

__ Psoriasis
__ Rashes
__ Perspire Easily
__ Hives

Other:_____

RESPIRATORY

__ Cough __ Coughing Blood __ Asthma
__ Pneumonia __ Coughing Phlegm __ Pain with Deep Breath
__ Shortness of Breath __ Bronchitis __ Nasal Congestion
__ Difficulty Inhalation __ Difficulty Exhalation __ Wheezing
__ Difficulty Breathing when Lying Down

Other:_____

GENERAL GASTROINTESTINAL

__ Nausea __ Vomiting __ Diarrhea __ Constipation
__ Gas __ Bloating __Belching __ Bad Breath
__ Abdominal Pain/Cramps __ Indigestion __Heartburn/Reflux __ Excessive Appetite
__ Rectal Pain/Bleeding __ Black Stools __ Blood in Stool __ Hemorrhoids
__ Sensitive Abdomen __ Retention of Food in Stomach __ Burping
__ Chronic Laxative Use __ Poor Appetite __ Unexplained Weight Loss
__ Excessive Thirst

Other:_____

GENITO-URINARY

__ Pain on Urination __ Frequent Urination __ Blood in Urine __ Urgency to Urinate
__ Unable to Hold Urine __ Kidney Stones __ Decrease in Urine Flow
__ Impotence __ Sores on Genitals __Waking at Night to Urinate
__ Dribbling Post Urination __ Change in Sex Drive
__ Frequent Urinary Tract Infections

Other:_____

MEN ONLY: __ Erection Difficulties __ Testicular Lump __ Penis Discharge
__ Prostate Enlargement __ Cold Feelings in Genitals
__ Testicle Pain __ Penis Pain __ Penis Sores
__ Premature ejaculation __ Impotence
__ Nocturnal Emission

Other:_____

WOMEN ONLY: Are you Pregnant? __ Yes __ No Trying to conceive? __ Yes __ No
Problems with conception? __ Yes __ No
Age of 1st Period_____ Age at menopause_____
# of Pregnancies ____# of live births_____
# of premature births ____ # of Miscarriages/Abortions_____
# of days between periods____ # of days of flow_____
__ Breast Lump/Swelling __ Hot Flashes __ Nipple Discharge
__ Vaginal Discharge __ Painful Intercourse
__ Abnormal Pap Smear __ Painful menses __ Irregular menses
__ Vaginal Odor __ Fibroids __ Ovarian Cysts
__ Sexually Transmitted Disease __ Vaginal Dryness
__ Decreased Sex Drive __ Strong menstrual odor
__ Urinary Tract Infection __ Premenstrual symptoms

Other:_____

Describe Menstrual Cycle

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal,bright red, pale, brown, rust, dark, purple, other)							
Flow (light, heavy, normal)							
Clots? (small, large, red, dark)							
Pain/Cramps (dull, ache, sharp)							
Nausea/vomit							
Energy level (normal, low, high)							
Headaches (dull, moderate, severe)							

MUSCULOSKELETAL
__ Neck Pain __ Back Pain __ Knee Pain __ Muscle Pain __ Foot/Ankle Pain
__ Shoulder Pain __ Hip Pain __ Hand/Wrist Pain __Sciatica
__ Muscle Weakness

Other:_____

PSYCHOLOGY AND NEUROLOGICAL

__ Seizures __ Dizziness __Loss of Balance __ Areas of Numbness
__ Poor Memory __ Lack of Coordination __ Concussion
__ Depression __ Anxiety __ Easily Stressed __ Confusion
__ Attempted Suicide __ Irritable __ Mania __ Panic Attacks
__ Mood Swings __ Worried __ Emotional Problems
__ Lack of Concentration __ Bad Temper/Violent Outburst
__ Seasonal Affective Disorders
Other:_____

SLEEP

__ Can't fall asleep but once asleep stays asleep __ Wakes Easily __ Irritability
__ Tossing and Turning __ Wake Up Early __ Easily Awakened
__ Grinds Teeth in Sleep __ Restless Sleep __ Dream Disturbed Sleep
__ Sleep Apnea __ Violent Dreams __ Dreamless Sleep
__ After Eating Lethargy or Sleepiness __ Fatigue After Eating
__ Wake Up During the Night __ Excessive Dreaming
Other:_____

AUTOIMMUNE AND INFLAMMATORY

__ Hashimoto's Disease (thyroid) __ Rheumatism __ Systemic Lupus
__ Erythematous __ Colitis __ Crohn's __ Alopecia (baldness)
__ Food Allergy __ Atopic Dermatitis __ Neurodermatitis
__ Cellulitis __ Sinus Allergy __ Vulvitis
Other:_____

Family Medical History *(circle all which apply &* ***specify which blood relative****- parents, grandparents, siblings)*

Cancer High Blood Pressure Hepatitis Rheumatic Fever Infectious Disease Heart Disease Seizures Emotional Disorder Tuberculosis
Other (please specify):_____
_____

MEDICATIONS AND SUPPLEMENTS

List medication and supplements you are currently taking
_____
_____

ALLERGIES
To medications or substances

_____
_____

HOSPITALIZATIONS and SURGERIES

_____

Do you have any scars? (note location of all operations or injury scars, even minor ones)

_____
_____

Beverage intake/Smoking/Recreational *(circle or fill out where necessary)*

Coffee Black Tea Caffeinated Beverages Recreational Drugs
Tobacco- Yes No Ever Smoked? Yes No - If yes, when quit:_____
a. If smoking, how many cigarettes do you smoke daily? __ b. How many packs do you smoke daily?___
Alcohol- Yes No Amount per day____ Per week___
Exercise (please specify type, how often, and length of time):_____

Lifestyle *(Please circle and elaborate where necessary)*

Hobbies Yes No
Type:_____ If no, why?_____
Do you feel you maintain a healthy balance between work and relaxation? Yes No
If no,explain_____
Travel: Places visited within the past year (any out of country travel?)_____
Working Environment: Good Bad (explain)_____
Home Environment: Good Bad (explain)_____

The information that I have documented on this form is accurate and I will advise the practitioner of any changes in my health or changed in my medications, nutritional supplements, and dietary habits. I will not hold my doctor or any members of his and her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient:_____Date:_____
Signature of Practitioner:_____Date:_____