EXTRAORDINARY ACUPUNCTURE

PATIENT INTAKE FORM

Patient Information

Name: _____ Telephone [cell]: _____
Address: _____ [work]: _____
City/State/Zip Code: _____ [home]: _____

Date of Birth: _____ Marital Status: _____
Height: _____ Weight: _____ Occupation: _____
E-Mail Address: _____
Emergency Contact Name # and Phone #: _____

Have you ever had an acupuncture treatment? Y/N Have you ever taken Chinese herbs? Y/N

Referred By: _____

Primary Health Care Provider

Primary Physician: _____
Address: _____
_____
Telephone: _____
I, hereby, give my acupuncturist(s) permission to consult with my primary health care provider regarding my health and treatment.
Initials: _____ Date: _____

Onset: Duration: Frequency: Location/Radiation: Intensity: Alleviate: Aggravate:	**CHIEF COMPLAINT**: _____ _____ _____ [If trauma related, cause of injury] _____

Secondary Complaints

Please identify other serious illnesses/injuries below: [If persistent symptoms after trauma-related injury, please describe any aggravating and/or relieving factors under "Outcome"]

Condition: _____
Treatment/Intervention/Medications: _____
_____
Outcome: _____

Condition: _____
Treatment/Intervention/Medications: _____
_____
Outcome: _____

Condition: _____
Treatment/Intervention/Medications: _____
_____
Outcome: _____

Surgeries/Procedures [If not already described in the treatment/intervention under secondary complaints, please list all surgeries including any major procedures.]

Type of Surgery/Procedure	Outcome

Hospitalization

Disease/Illness	Outcome

X-Rays/Cat Scans/MRI's/Mammography/Special Studies

Type of Diagnostic Test	(continued)

Medical History ***Symptoms***

[If you currently have or have had in the past year any of the following symptoms, please check the box.]

General
- ☐ chills
- ☐ fever
- ☐ weight loss
- ☐ weight gain
- ☐ night sweats
- ☐ excessive sweating

Muscle/Joint/Bone
- ☐ joints stiff
- ☐ joints swollen
- ☐ muscle weakness
- ☐ muscle pain
- ☐ bone pain

Pain, Weakness, Numbness in Any of the Following Areas:
- ☐ arms ☐ hips
- ☐ back ☐ legs
- ☐ feet ☐ neck
- ☐ hands ☐ shoulders

Genito-Urinary
- ☐ blood in urine
- ☐ frequent urination
- ☐ lack of bladder control
- ☐ painful "burning" urination
- ☐ difficulty starting to urinate

Gastrointestinal
- ☐ appetite poor
- ☐ bloating
- ☐ bowel changes
- ☐ constipation
- ☐ diarrhea
- ☐ excessive hunger
- ☐ gas
- ☐ hemorrhoids
- ☐ indigestion
- ☐ nausea
- ☐ rectal bleeding
- ☐ stomach pain
- ☐ vomiting
- ☐ vomiting blood

Cardiovascular
- ☐ chest pain
- ☐ high blood pressure
- ☐ irregular heart beat
- ☐ low blood pressure
- ☐ palpitations
- ☐ poor circulation
- ☐ rapid heart beat
- ☐ swelling of ankles
- ☐ numbness

Head, Eye, Ear, Nose, Throat [HEENT]
- ☐ bleeding gums
- ☐ blurred vision
- ☐ nearsighted
- ☐ farsighted
- ☐ crossed eyes
- ☐ difficulty swallowing
- ☐ double vision
- ☐ vision--flashes
- ☐ vision—halos
- ☐ ringing in ears
- ☐ loss of hearing
- ☐ earache
- ☐ ear discharge
- ☐ hay fever
- ☐ hoarseness
- ☐ nosebleeds
- ☐ nasal drainage
- ☐ sinus problems

Skin
- ☐ bruise easily
- ☐ hives
- ☐ itching
- ☐ changes in moles
- ☐ numbness

Respiratory
- ☐ shortness of breath
- ☐ cough
- ☐ productive cough
- ☐ sneezing
- ☐ wheezing
- ☐ asthma
- ☐ persistent cough

Neurological
- ☐ decreased memory
- ☐ dizziness
- ☐ frequent headaches
- ☐ insomnia
- ☐ nervousness
- ☐ tremors
- ☐ numbness or tingling
- ☐ fainting

Mental Health
- ☐ anxiety
- ☐ depression
- ☐ impaired concentration
- ☐ hallucinations
- ☐ mood swings

Medical History *Conditions*

[If you currently have or have had in the past year any of the following conditions, please check the box.]

☐ AIDS/HIV Positive ☐ Anemia ☐ Anorexia ☐ Appendicitis ☐ Arthritis [osteoarthritis or rheumatoid arthritis] ☐ Arthritis [lupus or scleroderma] ☐ Asthma ☐ Breast Lumps ☐ Bronchitis ☐ Bulimia ☐ Cataracts ☐ Chemical Dependency ☐ Chicken Pox ☐ CVA/stroke	☐ Diabetes ☐ Diptheria ☐ Emphysema ☐ Epilepsy/Seizures ☐ Fibromyalgia ☐ Food Allergies ☐ Fractures ☐ Gallstones ☐ Glaucoma ☐ Goiter ☐ Gonorrhea ☐ Gout ☐ Hepatitis ☐ Hernia ☐ Herpes ☐ High Cholesterol ☐ Kidney Disease [i.e. stones]	☐ Liver Disease [i.e. hepatitis or jaundice] ☐ Lung Disease [i.e. COPD] ☐ Measles ☐ Meningitis ☐ Migraine/Headaches ☐ Miscarriage ☐ Mononucleosis ☐ Multiple Sclerosis ☐ Mumps ☐ Nerve Compression/ Impingement ☐ Osteomyelitis ☐ Pneumonia ☐ Polio ☐ Prostate Problem ☐ Pulmonary Embolism ☐ Reflux Disease	☐ Rheumatic Fever ☐ Scarlet Fever ☐ Seasonal Allergies ☐ Suicide Attempt ☐ Spinal Disorders [i.e. scoliosis] ☐ Thyroid Disease ☐ Tonsillitis ☐ Tuberculosis ☐ Typhoid Fever ☐ Ulcer ☐ Vaginal Infections ☐ Vein Condition [i.e. varicose veins or phlebitis] ☐ Venereal Disease Other: _____ _____

Family Medical History [If you or any of your immediate relatives have had or currently have any of the following conditions, please check the box.]

☐ Alcoholism ☐ Allergies ☐ Alzheimer's Disease [early onset] ☐ Arthritis ☐ Asthma ☐ Bipolar Disorder ☐ Birth Defects	☐ Cancer ☐ Cardiovascular Disease ☐ Celiac Disease ☐ Chronic Fatigue Syndrome ☐ Colitis ☐ Depression/ Moodiness	☐ Diabetes ☐ Diptheria ☐ Hay Fever ☐ Hemochromatosis ☐ Hemophilia ☐ High Blood Pressure ☐ Hives ☐ Kidney Disease	☐ Leukemia ☐ Obesity ☐ Parkinson's Disease ☐ Pyroluria ☐ Seizures ☐ Schizophrenia ☐ Sickle Cell Anemia

Have you ever been left injured or impaired by any of the following types of accident?
☐ Automobile Accident ☐ Work-Related Accident ☐ Surgical Complication ☐ Athletic Injury ☐ Accident in Daily Living

Any Devices and/or Implants?
☐ Pacemaker/Defibrilator ☐ Breast ☐ IUD Other _____

Any Blood Transfusions? Y/N If yes, what year? _____

Any Organs Removed? ☐ Tonsils/Adenoids ☐ Appendix ☐ Uterus Other _____

Any Infections Contracted at a Hospital? Y/N If yes, please describe. _____
Any Reactions to Any Immunization? Y/N If yes, please describe. _____

How did you hear about us? _____
Would you like to receive our email newsletter? Y/N If yes, your email address: _____