Art of Acupuncture
Medical Intake Form

Today's Date _____/_____/_____

Name _____ Date of Birth ___/___/___ Age:____ Gender: _____

Address_____

City/ State/ Zip _____ email _____

Telephone: (home)_____ (work)_____ (cell) _____

Emergency Contact
Person/Relationship_____

Phone #_____

Name of your physician:_____ Tel:_____

Address of your physician: _____City _____State ____Zip Code_____

Can we contact your physician? Yes No

Referrals are the best compliments. Whom may we thank for your referral?

CURRENT MEDICAL ISSUES: Why are you seeking treatment?

_____

PAST MEDICAL HISTORY

Illnesses: _____

_____

Surgeries_____

_____

Significant Trauma (Auto accidents, falls, etc.) _____

_____

Do you have, or have you ever had, any **Infectious Diseases**? Yes _____ No _____

If so, please describe _____

Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

_____

_____

Allergies: (Respiratory, Diet, Skin, etc.)

_____

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) _____

Childhood health _____

Location of birth (Geographically prone to certain diseases, habits, etc.) _____

Current Emotional Health _____

Current Quality of Life _____

Current Predominant Emotion _____

Occupation _____Stress Level _____

Have you had any unusual stresses recently? _____

Hobbies & Recreational Habits _____

Do you have a regular exercise program? Yes _____ No _____ If so, please describe: _____

Have you traveled abroad in the past year? Yes _____ No _____ Where? _____

If applicable, please describe smoking or alcohol intake: _____

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side _____

Father's Side _____

Siblings _____

If any of the above is deceased, what was the cause? _____

PLEASE MARK IF YOU HAVE EXPERIENCED. INDICATE "C" FOR A CURRENT ISSUE AND "P" FOR A PAST ISSUE.

GENERAL

_____ Fevers _____ Chills _____ Night Sweats _____ Day Sweating _____ Change in Appetite

_____ Poor Appetite _____ Weight Loss _____ Weight Gain _____ Peculiar tastes or smells

_____ Fatigue _____ Sudden energy drops: What time of day? _____

_____ Poor Sleep/ Insomnia _____ Dream Disturbed Sleep

_____ Emotional Changes _____ Anxiety _____ Depression _____ Mania

_____ Bleeding or Bruising _____ Joint Pain _____ Localized Weakness

CARDIOVASCULAR

_____ High blood pressure _____ Low blood pressure _____ Swelling of Hands _____ Blood Clots

_____ Irregular heartbeat _____ Fainting _____ Palpitations _____ Chest pain _____ Swelling of Feet

_____ Varicose Veins _____ Spider Veins _____ Phlebitis _____ Cold Sweats _____ Cold Hands/Feet

RESPIRATORY

_____ Cough _____ Pain w/ Deep Breaths _____ Difficulty in Breathing _____ Asthma

_____ Bronchitis _____ Shortness of Breath _____ Easily Winded w/ Exertion _____ when laying down

_____ Coughing Blood _____ Production of phlegm: What Color? _____

GASTROINTESTINAL

_____ Nausea _____ Vomiting _____ Abdominal Pain/ Cramps _____ Digestive Disorders

_____ Constipation _____ Diarrhea _____ Acid Reflux _____ Indigestion _____ Belching

_____ Bad Breath _____ Parasites _____ Ulcers _____ Blood in Stools _____ Hernia

_____ Hemorrhoids

How many bowel movements a day? _____ Typically when? _____

DIET – WHAT IS YOUR TYPICAL DIET?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Are there any foods you crave? _____

Foods you don't tolerate? _____

What do you drink everyday? _____

How many servings you have per day? Coffee _____ Soda?_____ Juice?_____
Caffeinated tea?_____

Do you smoke? _____ Any recreational drug use? _____ # alcohol beverages a week? _____

GENITO-URINARY

_____ Pain on Urination _____ Decrease in Urine _____ Kidney sores _____ Urgent Urination

_____ Blood in Urine _____ Waking up to Urinate _____ Frequent Urination, How often? _____

_____ Impotency/ Infertility _____ Unable to Hold Urine _____ Genital Sores

MUSCULOSKELETAL

_____ Muscular Weakness _____ Arthritis _____ Recent Sprains _____ Muscle Cramps _____ Spasms

_____ Injuries or Falls _____ Muscular Atrophy _____ General Aches _____ Joint Instability

NEUROPSYCHOLOGICAL

_____ Seizures _____ Tremors _____ Concussion _____ Migraines _____ Headaches

_____ Fainting _____ Areas of Numbness _____ Lack of Coordination _____ Loss of Balance

_____ Disorientation _____ Dizziness _____ Poor Memory _____ Depression _____ Anxiety

Any other neurological or psychological conditions? _____

PREGNANCY & GYNECOLOGY

<table>
<tr>
<td>Age of 1st period (menarche)
_____

Age of last period (menopause)
_____</td>
<td>Are you pregnant?
Yes No

# of pregnancies _____

# of live births _____

# of abortions _____

# of miscarriages ____

Do you use an IUD?
Yes No</td>
<td>Last Exam Dates and Results

Gynecologic exam
_____

Pap smear
_____

Mammogram
_____

Bone density scan
_____</td>
<td>Have you been diagnosed with:

Fibroids?
Yes No

Fibrocystic breasts?
Yes No

Endometriosis?
Yes No

Ovarian cysts?
Yes No

Pelvic Inflammatory Disease?
Yes No

Other _____</td>
</tr>
<tr>
<td># of days between periods _____

# of days of flow _____

Color of flow
_____

Clots?
Yes No

Size of clots
_____

Heavy or Light Bleeding? _____</td>
<td colspan="3">Pain at Menses (Circle)
Location: Lower abdomen, Lower back, Thighs, Other _____
<u>Cramping</u> – before, during or after
<u>Stabbing</u> – before, during or after
<u>Burning</u> – before, during or after
<u>Dull</u> – before, during or after
<u>Bloating</u> – before, during or after
<u>Bearing down sensation</u> – before, during or after</td>
</tr>
<tr>
<td>Discharge -
thick, thin, watery?
Color?
_____
Odor?
_____
When?
_____</td>
<td colspan="2">Other symptoms related to menses
Check “✓” all that apply:
____Vaginal dryness
____ Nausea
____ Headache
____ Swollen breasts
____ Poor appetite
____ Ravenous appetite</td>
<td>____ Hot flashes
____ Night sweats
____ Insomnia
____ Vaginal infections
____ Decreased libido
____ Increased libido
____ Vaginal itching or sores</td>
</tr>
</table>

PAIN

Describe the location: _____

_____

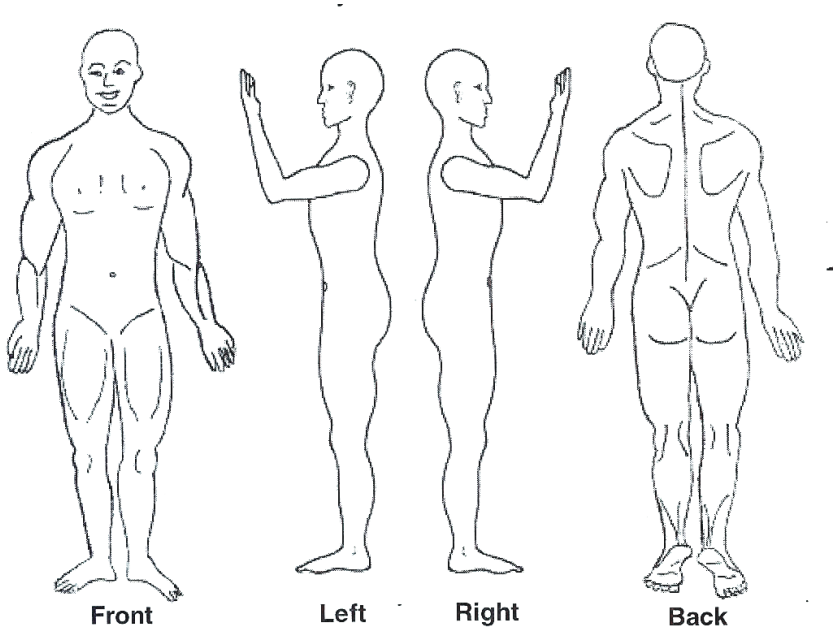
Quality of pain: (circle)
Dull, sharp, stabbing, sore, cramping, throbbing, burning, constant, radiating, fixed, moves about, severe, moderate

Rate the intensity of the pain. (circle)
(1 = A mild headache)

1 2 3 4 5

6 7 8 9 10

Mark on the figures the areas of pain.



Where does the pain radiates to:_____

Describe the onset of the pain:_____

What relieves the pain? (circle) ice heat rest movement a.m. p.m. dampness dry

What aggravates it? (circle): ice heat rest movement a.m. p.m. dampness dry

Is there any stiffness? Where? _____

Are there any movements that aggravate the pain? _____

How does exercise effect your pain? _____

What does the pain prevent you from doing? _____

Do any medications help your pain? _____

What other treatments have you had for the pain? _____

Any surgeries related to the pain? _____

Date of last prostate check up _____ PSA results _____ Manual Prostate Exam results _____ Lab results _____	**Frequency of Urination** Daytime _____ Nighttime _____ Color of Urine _____	
Symptoms related to prostrate: ____ Delayed Stream ____ Incontinence ____ Rectal Dysfunction ____ Back Pain	Check "✓" all that apply: ____ Dribbling ____ Retention of Urine ____ Impotence ____ Premature Ejaculation	Other _____ ____ Increased Libido ____ Decreased Libido ____ Groin Pain ____ Testicular Pain