



Acupuncture & Homeopathy Center

PATIENT INTAKE FORM

PATIENT INFORMATION

Name: _____ Date: _____

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

SS# _____ Date of Birth _____

Age _____ Weight _____ Height _____ Sex: male female Marital Status: single married other

Home Phone: _____ Mobile Phone: _____

Place of Employment _____

Occupation _____

Emergency Contact: _____ Phone: _____

Email Address: _____

How did you hear about us? _____

Medications (if any): _____

Supplements (if any vitamins, herbs, etc.): _____

Major Complaint(s), in order of significance to you:

1. Major Complaint: _____

2. Secondary Complaint: _____

Habits/excessive usage: alcohol chocolate cigarettes coffee cola drugs exercise food salt sex sugar

tea others: _____

How do these conditions impair your daily activities? _____

PATIENT MEDICAL HISTORY

How was your childhood health? _____

Hospital visits/stays? _____

RECENT TESTS: (please bring the copy of those)

Physical Cholesterol Blood Prostate HIV STD Pap Smear Mammography

Other: _____

FAMILY MEDICAL HISTORY

Check the following that have occurred in your blood relatives:

- Diabetes
- Tuberculosis
- Obesity
- Kidney Disease
- Allergies
- Alcoholism
- Cancer
- Heart Disease
- Stroke
- Bleeding Tendency
- Nervous Illness
- Mental Illness
- High Blood Pressure
- Other _____

PATIENT PROFILE

Overall Temperature (Kidney Function)

- cold hands
- cold feet
- hot flashes
- night sweats
- thirsty
- low energy
- sweaty feet
- cold sensation
- lack of perspiration
- hot sensation
- sweaty hands

EYES (Liver function)

- itchy
- bloodshot
- watery
- hot
- dry
- rough
- see floaters
- blurry vision

OVERALL ENERGY

(Kidney, Spleen, Lung function):

- low energy
- easily catch colds
- general weakness
- shortness of breath

LUNG FUNCTION:

- cough
- sinus congestion
- dry skin
- sneezing
- dry throat
- dry mouth
- body ache
- stiff neck
- dry nose
- sore throat
- nose bleeds
- chills and fever
- difficult breathing
- stiff shoulders
- melancholy

BLOOD (Liver, Spleen, Heart function):

- dizziness
- pale skin
- fatigue
- poor memory
- graying hair

HEART FUNCTION:

- anxiety
- chest pain
- insomnia
- palpitations
- mental fogginess
- restlessness
- mental confusion
- sore on tongue
- vivid dreams
- wake unrepressed
- afternoon flashes
- perspire easily
- vaginal dryness

SPLEEN FUNCTION:

- bloating
- loose stools
- diarrhea
- worry
- constipation
- gas
- over-thinking
- incomplete stools
- mucous in stools
- low appetite
- easily bruise
- hemorrhoids
- organ prolapsed
- gurgling stomach
- blood in stools
- abrupt weight change
- fatigue after eating
- undigested food in stools

DAMPNESS:

- heavy body
- snoring
- nausea
- sensation
- swollen joints
- swollen hands
- swollen feet

STOMACH FUNCTION:

- burning
- stomach pain
- heartburn
- ulcer
- belching
- hiccups
- acid reflux
- vomiting
- canker sores
- bad breath
- very large appetite
- bleeding or swollen gums

LIVER / GB FUNCTION:

- Rib pain
- anger easily
- twitching
- bitter taste

frustration

tingling

numbness

gall-stones

drink alcohol

lump in throat

muscles spasms

sexual disease

tightness in chest

frequent headaches

alternating diarrhea and constipation

KIDNEY/BLADDER FUNCTION

high libido

fearful

low back pain

excessive hair loss

memory problems

easily broken bones

sore/weak knees

lack of bladder control

URINATION:

frequent

clear color

profuse

painful

cloudy

strong odor

depression

irritability

ringing in ears

convulsions

muscle tension

seizures

low libido

normal libido

kidney stones

urgent

very little

burning

difficult

reddish color

dark yellow color

MEN ONLY:

low libido

impotence

premature ejaculation

Testicular pain

Prostate Problems

WOMEN ONLY:

Age of first period: _____

Age of first menopause: _____

Number Of pregnancies: _____

Number of life births: _____

Number of abortions: _____

Miscarriage: _____

Vaginal Discharge: _____

PMS

Cramps

Irregular cycles

excessive Menstrual Flow

clots in menses

Menopausal symptoms

Are you pregnant now? _____

Check any you have had in the past:

- | | | | |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lung illness | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Heart illness | <input type="checkbox"/> STD |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver illness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Vein Condition | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney illness |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach illness |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Spleen illness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> High Blood Press. |
| <input type="checkbox"/> Other: _____ | | | |

Surgeries: _____

Patient Profile

Please clearly mark any areas of pain on the diagram on the following page:

Is the pain:

- Sharp Burning Aching Cramping Dull Moving Fixed Other: _____

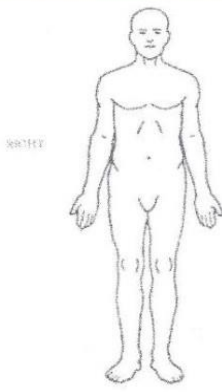
What make the pain better?

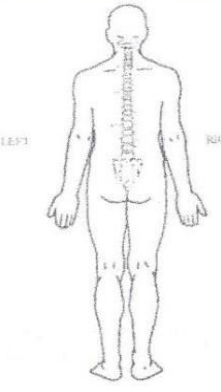
- Pressure Cold Heat Exercise Other: _____

What make the pain worse?

- Pressure Cold Heat Exercise Other: _____

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)





Complaint Index

B Burning **S** Sharp/Stabbing
N Numbness/Tingling **A** Ache

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "BB" on the neck of the illustration.

If this is an injury, describe what happened:

On a scale of 0-10, how do you feel now? (0 Being Fantastic, 10 Being Extremely Poor)

