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:

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

PATIENT PROFILE

Overall Temperature (Kidney Function)

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

EYES (Liver function)

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

OVERALL ENERGY

(Kidney, Spleen, Lung function):

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

LUNG FUNCTION:

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

BLOOD (Liver, Spleen, Heart function):

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

HEART FUNCTION:

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

SPLEEN FUNCTION:

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

DAMPNESS:

- o heavy body o snoring
- o nausea o sensation
- o swollen joints
- o swollen hands
- o swollen feet
- o chest congestion

STOMACH FUNCTION:

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

LIVER / GB FUNCTION:

- o Rib pain o anger easily
- o twitching o bitter taste
- o frustration
- o tingling
- o numbness
- o gall-stones
- o drink alcohol
- o lump in throat
- o muscles spasms
- o sexual disease
- o tightness in chest
- o frequent headaches
- o alternating diarrhea and constipation
- o depression
- o irritability
- o ringing in ears
- o convulsions
- o muscle tension
- o seizures

KIDNEY/BLADDER FUNCTION

- o high libido
- o fearful
- o low back pain
- o excessive hair loss
- o memory problems
- o easily broken bones
- o sore/weak knees
- o lack of bladder control
- o low libido
- o normal libido
- o kidney stones

URINATION:

- o frequent
- o clear color
- o profuse
- o painful
- o cloudy
- o strong odor
- o urgent
- o very little
- o burning
- o difficult
- o reddish color
- o dark yellow color

MEN ONLY:

- o low libido
- o impotence
- o premature ejaculation
- o Testicular pain
- o Prostate Problems

WOMEN ONLY:

Age of first period:_____

Age of first menopause:_____

Number Of pregnacies:_____

Number of life births:_____

Number of abortions:_____

Miscarriage:_____

Vaginal Discharge:_____

- o PMS
- o Irregular cycles
- o excessive Menstrual Flow
- o clots in menses
- o Menopausal symptoms
- o Cramps

Are you pregnant now?_____

Check any you have had in the past:

o Diabetes	o Chicken Pox	Lung illness	o HIV
o Heart Disease	o Polio	o Heart illness	o STD
o CVA (stroke)	o Hepatitis	o Liver illness	o Tuberculosis
o Vein Condition	o Measles	o Rheumatic Fever	o Kidney illness
o Syphilis	o Cancer	o Jaundice	o Stomach illness
o Meningitis	o Migraines	o Bleeding Tendency	o Spleen illness
o Epilepsy	o Glaucoma	o Nervous Disorder	o Thyroid Disorder
o Paralysis	o Asthma	o Mononucleosis	o Mumps
o Allergies	o Emphysema	o Multiple Sclerosis	o High Blood Press.

o Other:_____

Surgeries:_____

Patient Profile

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

Is the pain:

oSharp oBurning oAching oCramping oDull oMoving oFixed oOther:_____

What make the pain better?

oPressure oCold oHeat oExercise oOther:_____

What make the pain worse?

oPressure oCold oHeat oExercise oOther:_____