EXTRAORDINARY ACUPUNCTURE
PATIENT INTAKE FORM

Patient Information

Name: ________________________________ Telephone [cell]: ____________________

Address: ______________________________ [work]: ____________________

City/State/Zip Code: ____________________ [home]: ____________________

Date of Birth: __________ Contact Person's Name (i.e., spouse) and telephone: _____________________

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: ______________________________

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Telephone: ______________________________

I, hereby, give my acupuncturist(s) permission to consult with my health care provider(s) 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 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? Y/N

☐ 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. ____________________________

Any Root Canals? Y/N

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

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