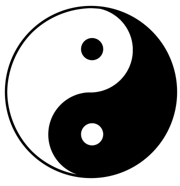
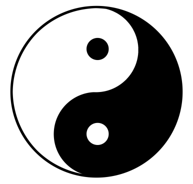

RENEWED
HEALTH & WELLNESS

Acupuncture Intake Form

Patient Name: ____ Date of Birth: ____/_____/_______
Last First Middle Initial

Sex: □ M □ F Marital Status: □ S □ M □ D □ W Today's Date ______/______/_______

Patient Social Security #: ______-______-______ Responsible Party SS# ______-_____-__________

Primary Address:____
Street City State Zip

Home Phone: ( ) _______-______________ Cell Phone: ( ) _________-______________

Email Address: ____

How did you hear about our clinic? ____

Have you been treated by Acupuncture or Oriental medicine before? _____________________________

Name of your Primary Care Physician:____

Telephone Number of your Primary Care Physician ( ) _____________- _____________________

Emergency Contact: ____________________________________ Tel: ( ) ________ - ____________

<u>Main Complaint and Present Medical History</u>

Main Problem you would like help with: ____

____

____

How long ago did this problem begin? ____

Have you been given a diagnosis for this problem? If so, what? ____________________________________

What types of treatment have you tried? ____

Are you currently receiving treatment for your problem? If so, please _____________________________

____

Does anything improve your problem? ____

Have you had any significant illness or hospitalizations in the last year? □ Yes □ No
If yes, please specify: ____
____

Please list any surgical procedures you have had with dates:
____ ____
____ ____

Please list any history of trauma you have experienced (ie car accidents, head injuries, broken bone):
____ ____
____ ____

Please indication if you are currently receiving or has ever received any of the following:

□ Radiation Therapy Condition: ____
□ Chemotherapy Condition: ____

Are you allergic to any foods? □ Yes □ No
If yes, what food(s) and describe the reaction: ____

Are you allergic to any medication? □ Yes □ No
If yes, what medication and describe the reaction:
____
____

Please list all medication are currently taking. Include prescription, vitamins, herbal supplements and over the counter medication with dosage and frequency:

Medication	Condition	Dosage	Times per day

Patient's Name: ____________________________________ Date of Birth: _____________ Date:________________

Vitals: B/P _________ Pulse _______ Temp _________ Height _________ Weight ________ Head __________

Personal History

Born at term? (near due date) □ Yes □ No □ Unknown

Childhood Health:____

Location of upbringing (geographincally prone to certain diseases, habits, etc) :______________________________

____

Current Emotional Health ____

Current Relationship/Quality ____

Current Predominant Emotion ____

Occupation ____ Stress Level __________________________________

Have you had any unusual stresses recently? ____

Favorite time of year (body type) ___________________________ Worst _______________________________________

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: ____

Neuropsychological

□ Seizures	□ Areas of Numbness	□ Anxiety
□ Concussion	□ Lack of Coordination	□ Poor Memory
□ Dizziness	□ Loss of Balance	□ Easily Angered
□ Headaches	□ Fainting	□ Depression
□ Migraines	□ Disorientation	□ Mania
□ Easily Susceptible to stress		

Have you ever been treated for emotional problems? ____

Have you ever considered or attempted suicide? ____

Any other neurological or psychological problems? ____

Any nervous habits? ____

Pregnancy & Gynecology

_____ Age at First Menses	_____ Number of Pregnancies	□ Birth Control?
_____ Period between Menses	_____ Number of Birth	What type? ____________________
_____ Duration of Menses	_____ Miscarriages	How long? _____________________
□ Unusual Character	□ Abortions	□ Fertility Problems
□ Heavy or □ Light	□ Difficult Births	□ Vaginal Discharge
□ Irregular Periods	□ Breast Lumps	□ Vaginal Sores
□ Painful Periods	□ Clots	

First Date of last menstrual cycle _____/_______/_________ Date of last Pap Smear ______/_______/_________

Do you experience changes in body and/or Psyche prior to menstruation? □ Yes □ No

If so, please explain: ____

Patient's Name: _____________________________________ Date of Birth: _____________ Date:________________

Vitals: B/P _________ Pulse _______ Temp _________ Height _________ Weight ________ Head __________

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE(3) MONTHS):

GENERAL

□ Fevers
□ Chills
□ Fatigue
What time of day? ________________________
□ Poor sleep/Insomnia
□ Dream Disturbed Sleep
□ Depression
□ Mania
□ Emotional changes
□ Tremors
□ Seizures
□ Night sweats
□ Day sweating
□ Poor Balance
□ Weight Loss
□ Weight Gain
□ Poor Appetite
□ Change in Appetite
□ Peculiar tastes or smells
□ Sudden energy drops?
□ Strong thirst for hot or cold drinks?
□ Headaches
□ Localized Weakness
□ Bleeding or Bruising
□ Joint pain

CARDIOVASCULAR

□ High blood pressure
□ Irregular heartbeat
□ Low blood pressure
□ Chest pain
□ Dizziness
□ Fainting
□ Cold sweats
□ Swelling of Feet
□ Swelling of hands
□ Difficulty in breathing
□ Cold Hands/Feet
□ Phlebitis
□ Blood Clots
□ Palpitations

RESPIRATORY

□ Cough
□ Asthma
□ easily winded w/exertion when laying down
□ Pain w/deep breaths
□ Bronchitis
□ Difficulty in breathing
□ Shortness of Breath
□ Production of phlegm
what color? _________________

GASTROINTESTINAL

□ Nausea
□ Vomiting
□ Indigestion
□ Ulcers
□ Hernia
□ Abdominal Pain/ Cramps
□ Parasites
□ Belching
□ Bad Breath
□ Hemorrhoids
□ Digestive Disorders
□ Constipation
□ Diarrhea
□ Blood in stools

GENITO-URINARY

□ Pain on urination
□ Urgent urination
□ Frequent urination
□ Decrease in urine
□ Blood in urine
□ impotency/infertility
□ Kidney sores
□ Waking up to urinate
How often? ___________________________

MUSCULOSKELETAL

□ Muscular Weakness
□ Muscle
□ Injuries or Falls
□ General Aches
□ Arthritis
□ Spasm
□ Muscular Atrophy
□ Joint Instability
□ Recent Sprains

Patient's Name: ______________________________________ Date of Birth: ______________ Date:_________________

Vitals: B/P __________ Pulse ________ Temp __________ Height __________ Weight _________ Head ___________