# Acupuncture Intake

This is a confidential questionnaire to help us determine the best possible treatment plan for you.

| First Name | Last Name | Date |
|---|---|---|

Address: ________________________________________ City___________________ State_____ Zip_______________
Home Phone: ______________________ Cell Phone: __________________ Email:
_______________________________
Birth-date: ____________ Emergency Contact ___________________ Emergency Contact Phone___________________
Primary Physician ______________________________ Phone Number __________________
Person Responsible for your account ___________________________________
Who can we thank for referring you?: ___________________________________
Sex: ___M___F Height :_______ Weight:_______ Birth date:____________ Age:______
Marital Status: ___Married ___Single ___Divorced ___Widowed # of Children: _____

**Please indicate any significant illnesses you or one of your blood relatives have had:**

| Illness | You | Which Relative | Approx. Age | Illness | You | Which Relative | Approx. Age |
|---|---|---|---|---|---|---|---|
| Cancer | ____ | _______ | ____ | Diabetes | ____ | _______ | ____ |
| High Blood Pressure | ____ | _______ | ____ | Seizures | ____ | _______ | ____ |
| Rheumatic Fever | ____ | _______ | ____ | Emotional Disorders | ____ | _______ | ____ |
| Infectious Diseases | ____ | _______ | ____ | Tuberculosis | ____ | _______ | ____ |

**Sexually Transmitted Diseases**: __gonorrhea __syphilis __HIV __HPV __Chlamydia Date?____

**Please indicate the use and frequency of the following:**

| | Yes | No | Amount | | Yes | No | Amount |
|---|---|---|---|---|---|---|---|
| Coffee/black Tea | ___ | ___ | _______ | Tobacco | ___ | ___ | _______ |
| Water Intake | ___ | ___ | _______ | Recreational Drugs | ___ | ___ | _______ |
| Alcohol | ___ | ___ | _______ | Soda Pop | ___ | ___ | _______ |

**Please check if any of the following statements are true:**
I am taking coumadin/warfarin ____ I have a pacemaker ____
I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs) ____
I have known allergies____ Please list_____________________________________________

**List any medications or supplements you are currently taking:**

| Medicine | Dosage | Reason | How Long | Prescribed By | Last checkup |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

What is the primary reason for your visit today?

What other forms of treatment have you had?

List any other complaints or health problems you have:

List any allergies, food sensitivities or food cravings that you have:

List any accidents, surgeries, or hospitalizations (include date):

Lab results of X-rays, MRI, CAT Scan, ultrasound:

## For Women

Age of 1st period (menarche) ____ Are you pregnant? ___ Yes ___ No # of pregnancies _______

Age of last period (menopause) ____ # of births____ # of abortions____ # of miscarriages______

Date of last Gyn exam ______ Pap smear results _______________ Date of last Mammogram_______

Date of last Bone Density Scan _____ Results from both________________________________________

Number of days between periods _____ Number of days of flow _____ Color of flow ___________

Clots? ___ Average number of tampons/pads you use per day: 1st___ 2nd____ 3rd____ 4th____ +days___

Have you been diagnosed with: __Fibroids __Fibrocystic Breasts __Endometriosis __Ovarian Cysts __PID

**Nature of Pain (Check all that Apply;** Please indicate before, during, or after menses**)**

___Cramping ___Stabbing ___Discharge ___Vaginal Dryness ___Headache

___Burning ___Aching ___ Nausea ___ Constipation ___ Diarrhea

___Dull ___Bloating ___Swollen Breasts ___ Mood Swing ___ Hot Flashes

___Consistent ___ Night Sweating ___ Increased Libido ___Decreased Libido

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## For Men

Date of last prostate checkup _____ PSA Results___________ Lab Results_ ____________________

Frequency of urination: Daytime _____ Nighttime _____ Color of Urine: ___Clear ___Murky Odor: ____

Symptoms related to prostate (check all that apply):

___ Delayed stream ___ Dribbling ___ Incontinence ___Retention of Urine

___ Rectal Dysfunction ___ Increased libido ___ Decreased libido ___ Premature ejaculation

___ Impotence ___ Back pain ___ Groin Pain ___ Testicular pain

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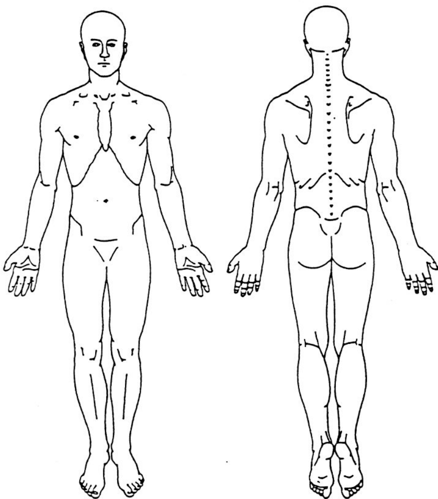
**PAIN PATIENTS**, please indicate on the figures below the areas of the body you experience your pain:



**How would you characterize your pain?:**

□ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

**Describe the onset of your pain (include if it was gradual or acute):**

**Helps Pain (circle):** ice heat rest movement a.m. p.m. dampness dry

**Aggravates (circle):** ice heat rest movement a.m. p.m. dampness dry

Are there any movements that aggravate the pain?

How does exercise affect your pain?

Do any medications help your pain?

## Symptom Survey

If you experience any of these symptoms place an X for frequently and an O for occasionally.

___ lack of appetite
___ excessive appetite
___ loose stool
___digestive problems
___ vomiting
___ belching, burping
___ heartburn/reflux
___ feeling retention of food in the stomach
___tendency to become Obsessive in work & Relationships

___insomnia, diff sleeping
___heart palpitation
___cold hands and feet
___nightmares
___mentally restless
___laughing for no reason
___angina pains
___abdominal pain
___chest pain
___sciatic pain
___headaches
___pain or cold in genital

___cough
___shortness of breath
___low sense of smell
___nasal problems
___skin problems
___feeling of claustrophobia
___bronchitis
___colitis, diverticulitis
___constipation
___hemorrhoids
___recent use of antibiotics

___eye problems
___ Jaundice
___difficulty digesting oil
___gall stones
___light colored stool
___soft or brittle nails
___easily angered
___difficulty with decisions
___spasms or twitching muscles

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___low back pain
___knee problems
___hearing impairment
___ear ringing
___kidney stones
___decreased sex drive
___hair loss
___urinary impairment

___fatigue
___edema
___blood in stool
___black tarry stool
___bruise easily
___difficult to stop bleeding
___asthma
___tendency to catch colds easily

___intolerance to weather changes
___allergies
___hay fever
___dizziness
___tendency to faint easily
___high cholesterol levels
___sudden weight loss

## Acupuncture and Oriental Medicine Consent Form

I the undersigned do hereby authorize the licensed acupuncturist treating me to perform the following:

- **Acupuncture**: the insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the body.
- **Electro Acupuncture**: Small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat**: Applying heat generated by an infrared lamp over a specific area of the body.
- **Moxa**: Indirect burning of an herbal compound on acupoints with moxa pole or loose moxa.
- **Cupping**: Cups made of glass are placed on the skin with a vacuum created by heat or suction device.
- **Tui Na**: Traditional Chinese medical massage and manual therapy.
- **Liniments, Oils, Plasters:** Herbal formulas applied topically to the skin.
- **Nutritional Advice:** Includes diet, herbal and supplement recommendations**.**

I have had an opportunity to ask any questions about these procedures, and I voluntarily consent to having the licensed acupuncturists stated above perform one or more of these actions. I understand there are no guarantees that these procedures will cure or improve my condition. In order for Judy Ferguson and Jennifer Aliano to perform these procedures, I release them from any and all liability that may occur in connection with my treatment.

_______________________________________________ _______________________

Signature of patient (or guardian if under 18) Date