Acu-Care

MOBILE ACUPUNCTURE SERVICES

Acupuncture Herbal Medicine Whole Food Nutrition Holistic Animal Care

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PATIENT INTAKE FORM

Today's Date:________________Date of Birth:_____________________Age:_____________

Name:____

Home Address:____Apt.:___________

City:____State:_________Zip:________________

Home Phone: (______)_________________Email:___________________________________

Work Phone: (______)_______________________Cell:_______________________________

What is your preferred method of contact: Call Text Email

May I leave voicemail/text messages/emails regarding appointments? Yes No

Emergency contact:_______________________Emergency phone:____________________

Marital Status: M S D W Number of Children:________________
(check one only)

Who should I thank for referring you?____

Are you employed? Yes No If so, what is your occupation?________________

CURRENT MEDICAL HISTORY

List which health problems you are seeking treatment for in order of importance to you:
(i.e. #1 being most painful or problematic, #4 being least painful or problematic)

I.________________________________ 3.________________________________

2.________________________________ 4.________________________________

List any medications, supplements and/or herbs you are currently taking and why:

I.________________________________ 3.________________________________

2.________________________________ 4.________________________________

Are you taking Coumadin/Warfarin? Yes No

List any allergies:____

Do you have a pacemaker? Yes No Are you pregnant? Yes No

Do you have any of the following: Yes No

☐ 1. A change in bowel or bladder habits
☐ 2. A sore that doesn't heal
☐ 3. Any unusual bleeding or discharge
☐ 4. Thickening or lump in breast or elsewhere
☐ 5. Indigestion or difficulty swallowing
☐ 6. Obvious change in a wart or mole
☐ 7. Nagging cough or hoarseness

PAST MEDICAL HISTORY

List any accidents, surgeries or hospitalizations, including approximate dates:

1.________________________________ 3.________________________________

2.________________________________ 4.________________________________

Indicate any significant illness **you** have now or have had previously:

☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ Heart Disease ☐ Emotional Disorders ☐ HIV

Please indicate the use and frequency of the following substances:

Tobacco/Marijuana:________________ Coffee/Black Tea:________________
Alcohol:__________________________ Drugs:__________________________

CURRENT HEALTH STATUS

A. Your current stress level is:

Low Medium High

B. Any recent use of antibiotics?

Yes No

C. Your current weight is_______lbs.

D. Your current height is_____ft._____inches

E. Your last cholesterol level:______

F. Your last blood pressure reading:____/____

GENERAL HEALTH QUESTIONNAIRE (please check appropriate answers)

BODY TEMPERATURE

1. In general, your body temperature is:

cold all over cold hands & feet normal hot

2. Are you currently having any of the following:

low grade fever fever chills none

PERSPIRATION

1. Do you:

sweat too easily sweat on exertion only cannot sweat night sweat

HEADACHES/DIZZINESS

1. Do you have headaches: yes no
2. If you do, how often do you have them:

daily weekly monthly rarely

3. Where is the pain:

frontal/sinus temples side of head back of head top of head

4. Do you have dizziness? yes no

PAIN

1. Are you currently having pain? yes no

2. If you are having pain is it best described as:

   dull/achy sharp/stabbing heavy sensation moves around

3. The pain is better with: heat cold no change

4. Touch or pressure makes the pain: better worse no change

5. After eating the pain is: better worse no change

6. The type of weather that makes it worse is: hot damp cold no change

7. On a scale of 1-10, your pain is usually: (i.e., 1 is mild; 10 is the worst you can imagine)

   0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

APPETITE/THIRST

1. How many times per day do you eat including snacks?

   1 2 3 4 5

2. Your appetite is: low medium excessive

3. The amount of thirst you experience is: low medium excessive

4. You like your drinks to be: hot room temp. cold

SLEEP

1. Do you wake up feeling rested? yes no

2. How many hours do you usually sleep? 5-6 7-8 9-10

3. Do you have difficulty sleeping? yes no

4. Do you have trouble with: falling asleep staying asleep nightmares

EMOTIONAL/MENTAL

1. Do you experience any of the following frequently?
   depression irritability worry fear anxiety anger

URINATION

1. Usually, how many times do you urinate each day? 1-2 2-3 4-5 5+
2. Usually, how many times do you urinate each night? 0 1 2 3+
3. Is there any pain or discomfort on urination? yes no

ELIMINATION

1. How many times do you move your bowels each day? 0 1 2 2+
2. The consistency of the stool is? diarrhea loose formed over dry

WOMEN ONLY

1. Do you have a menstrual cycle? yes no Age of Menopause__________
2. Are you using birth control? yes no What type?__________________
3. Is your cycle regular? yes no How many days does it last?_____________
4. Do you have any problems related to your cycle? PMS Cramps
   Breast Tenderness Spotting Between Yeast Infections
5. Have you been diagnosed with any of the following? Fibroids PID
   Fibrocystic Breasts Endometriosis Ovarian Cysts

7. When was you last gynecological exam?____________Results:______________

MEN ONLY

1. Do you have any of the following: Sexual Dysfunction Impotence
   Urine Retention/Dribbling Delayed Stream Testicular Pain/Mass
2. Have you had a P.S.A. test? yes no Results?_________________

MEN & WOMEN:

Have you been diagnosed with any sexually transmitted disease/s? Yes No
Herpes HPV Chlamydia Syphilis Other_______________