Initial Intake

This is a CONFIDENTIAL questionnaire to help us determine the best individualized treatment plan for you. Thank you for taking the time to answer as thoroughly as possible. If you have any questions, please ask.

Personal Information

Name ____ Date _______________________________

Home Address ____

City __________________________________ State ___________ Zip ___________________________

Home Phone ____________________ Work ____________________ Cell Phone ____________________

Occupation _______________________ Email Address: ____

Gender: ☐ Male ☐ Female ☐ Non-binary/ third gender ☐ Prefer not to say ☐ Prefer to self-describe

Height _________ Weight ________ Birth date _________ Age __________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Co-habitating # of children ___________

Have you ever received acupuncture before? ☐ Yes ☐ No

When? _________________________________ With whom? _____________________________________

Have you ever taken Chinese herbs before? ☐ Yes ☐ No

When? _________________________________ By whom? _______________________________________

Whom were you referred by? ____

What are the main health problems which you are seeking treatment? _____________________________________

____

What other forms of treatment have you sought? ____

List any other health problems you now have? ____

____

List any allergies, food sensitivities, or food ravings that you have. ____

____

List any accidents, surgeries, or hospitalizations (include date). ____

____

When was the last time you saw a dentist? ____

Do you have any suspicion of a hidden dental infection? ____

When was the last time you had blood work? ____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	☐	☐	______	Diabetes	☐	☐	______
Hepatitis	☐	☐	______	Heart Disease	☐	☐	______
High Blood Pressure	☐	☐	______	Seizures	☐	☐	______
Rheumatic Fever	☐	☐	______	Emotional Disorders	☐	☐	______
Infectious Diseases	☐	☐	______	Tuberculosis	☐	☐	______

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ AIDS ☐ HPV ☐ Herpes Date ______

List any medications and supplements you are currently taking: (Continue on back if necessary.)

Medicine / Supplement	Dosage	Reason	How Long	Prescribed by

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/Black tea	☐	☐	______	Tobacco	☐	☐	______	Water Intake	☐	☐	______
Non-medical drugs	☐	☐	______	Alcohol	☐	☐	______	Soda pop	☐	☐	______

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	☐	☐	☐	☐	☐	______
Family	☐	☐	☐	☐	☐	______
Diet	☐	☐	☐	☐	☐	______
Sex	☐	☐	☐	☐	☐	______
Self	☐	☐	☐	☐	☐	______
Work	☐	☐	☐	☐	☐	______
Exercise	☐	☐	☐	☐	☐	______
Spirituality	☐	☐	☐	☐	☐	______

For Woman

Age of 1st period (menarche) __________ Are you pregnant? ☐ Yes ☐ No # of pregnancies ____________

Age of last period (menopause) _______ # of live births _______ # of abortions ______ # of miscarriages _______

Number of days between periods _____ Date of last: GYN Exam _____________ Pap Smear _______________

Number of days of flow ______________ Mammogram ______________ Bone Density Scan ___________________

Color of flow ______________________ Results ____

Clots? ☐ Yes ☐ No Color _________ ____

Average number of pads you use per day: 1st day ______ 2nd _____ 3rd _____ 4th _____ + days _______

Location of pain: ☐ Lower abdomen ☐ Lower Back ☐ Thighs ☐ Other __________________________

Nature of Pain (please indicate before, during or after menses)

Cramping _____________ Stabbing _______________

Burning ______________ Aching ________________

Dull _________________ Bloating _______________

Consistent ____________ Intermittent _____________

Bearing down sensation _________________________

Other symptoms related to menses

☐ Discharge ☐ Vaginal dryness ☐ Headache

☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Swollen Breasts ☐ Mood swings ☐ Ravenous appetite

☐ Poor appetite ☐ Hot flashes ☐ Night sweats

☐ Increased libido ☐ Decreased libido ☐ Insomnia

Have you ever been diagnosed with:

☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID Other _____________

Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
No mark = never experience **Check mark** √ = sometimes experience **Plus sign** + = frequently experience

___ lack of appetite
___ excessive appetite
___ loose stool or diarrhea
___ digestive problems, indigestion
___ vomiting
___ belching, burping
___ heartburn/reflux
___ feeling the retention of food in the stomach
___ tendency to become obsessive in work, relationships

___ insomnia, difficulty sleeping
___ heart palpitations
___ cold hands and feet
___ nightmares
___ mentally restless
___ laughing for no apparent reason
___ angina pains

___ abdominal pain
___ chest pain
___ sciatic pain
___ headaches
___ pain or coldness in the genital area

___ cough
___ shortness of breath
___ decreased sense of smell
___ nasal problems
___ skin problems
___ feeling of claustrophobia
___ bronchitis
___ colitis or diverticulitits
___ constipation
___ hemorrhoids
___ recent use of antibiotics

___ eye problems
___ jaundice (Yellowish eyes or skin)
___ difficulty digesting oily foods
___ gall stones
___ light colored stool
___ soft brittle nails
___ easily angered or agitated
___ difficulty in making plans or decisions
___ spasms or twitching of muscles

___ low back pain
___ knee problems
___ hearing impairment
___ ear ringing
___ kidney stones
___ decreased sex drive
___ hair loss
___ urinary problems

___ fatigue
___ edema
___ blood in stool
___ black tarry stools
___ easily bruised
___ 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