



Today's date: \_\_\_/\_\_\_/\_\_\_

**INITIAL INTAKE FORM**  
**ALL INFORMATION IS CONFIDENTIAL**

**PERSONAL INFORMATION**

Name:			
Date of birth:		Social security number:	
Age:	Height:	Weight:	Gender:
Street:		City:	State: Zip:
Cell phone:		Home phone:	
Occupation:		Marital Status:	# of children:
E-mail:		In Emergency Notify:	Phone #:
Referred by:		May we send a thank you note? Yes / No	
Family Physician:			
Insurance Carrier:		Policy Number:	
Have you tried acupuncture or Chinese herbal medicine before?			

**MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS**

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

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How long has it been since you first noticed any symptoms?

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Have you been given a diagnosis for the problem by a physician?

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If so, what is it?

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What kinds of treatment or therapy have you tried?

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**If any of the following apply, please check the box:**

- Do you have history of fainting/seizures?**
- Are you on blood thinner medications (coumadin/warfarin)?**
- Are you pregnant?**

**PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergies:  | <input type="checkbox"/> Rheumatic fever                | <input type="checkbox"/> Other significant illness |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Surgeries (describe)           | <input type="checkbox"/> Accidents                 |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Venereal disease               |  |
| <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Thyroid disease                |  |
| <input type="checkbox"/> High blood pressure                                     | <input type="checkbox"/> Birth trauma (prolonged labor) |  |
| <input type="checkbox"/> Heart disease forceps delivery, etc.) trauma (describe) |   |  |
| <input type="checkbox"/> Seizures  |   |  |

**OTHER RELEVANT MEDICAL HISTORY**

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### FAMILY MEDICAL HISTORY

- |                                    |  |                                   |
|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other    |

### LIFESTYLE

Do you follow a regular exercise program? If so, please describe: \_\_\_\_\_

Please describe your average daily diet: \_\_\_\_\_

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Special diet: \_\_\_\_\_

Food allergies: \_\_\_\_\_

- Cigarette smoking       Coffee, tea or cola       Alcoholic beverages

Do you often feel thirsty? Yes / No.      Do you prefer warm or cold drinks? \_\_\_\_\_

Do you crave salty / sweet / sour? \_\_\_\_\_

How many hours do you sleep at night? \_\_\_\_\_

Do you have difficulties (check all that apply): Falling asleep\_\_ Staying asleep\_\_ Dream disturbed sleep\_\_

List medications taken within the last two months (vitamins, drugs, herbs, etc.): \_\_\_\_\_

Please describe any use of drugs for non-medical purposes: \_\_\_\_\_

**PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.**

### GENERAL

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Poor appetite      | <input type="checkbox"/> Weight gain              | <input type="checkbox"/> Night sweats       |
| <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Weight loss              | <input type="checkbox"/> Fever              |
| <input type="checkbox"/> Disturbed sleep    | <input type="checkbox"/> Changes in appetite      | <input type="checkbox"/> Chills             |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Sweating easily          | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Cravings           | <input type="checkbox"/> Tremors (time of day?)   | <input type="checkbox"/> Poor balance       |
| <input type="checkbox"/> Strong thirst      | <input type="checkbox"/> Bleeding/bruising easily |   |

Other unusual or abnormal conditions you have noticed in your general sense of health \_\_\_\_\_

### SKIN & HAIR

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Recent moles               |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Pimples       | <input type="checkbox"/> Changes in texture of hair |
| <input type="checkbox"/> Hives       | <input type="checkbox"/> Dandruff skin |   |
| <input type="checkbox"/> Itching     | <input type="checkbox"/> Hair loss     |   |

Any other hair or skin problems \_\_\_\_\_

### HEAD, EYES, EARS, NOSE, THROAT

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Color blindness        | <input type="checkbox"/> Nose bleeds              |
| <input type="checkbox"/> Concussions            | <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Jaw clicks               |
| <input type="checkbox"/> Migraines              | <input type="checkbox"/> Blurry vision          | <input type="checkbox"/> Grinding teeth           |
| <input type="checkbox"/> Glasses                | <input type="checkbox"/> Earaches               | <input type="checkbox"/> Sores on lips/tongue     |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Facial pain              |
| <input type="checkbox"/> Eye pain               | <input type="checkbox"/> Poor hearing           | <input type="checkbox"/> Teeth problems           |
| <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Sinus problems         | <input type="checkbox"/> Headaches (where? when?) |
| <input type="checkbox"/> Night blindness        | <input type="checkbox"/> Recurrent sore throats |   |

Any other head or neck problems \_\_\_\_\_

**CARDIOVASCULAR**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling of feet        |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Blood clots             |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands   | <input type="checkbox"/> Phlebitis               |

Any other heart or blood vessel problems

**RESPIRATORY**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Bronchitis                           | <input type="checkbox"/> Difficulty breathing when |
| <input type="checkbox"/> Coughing up blood   | <input type="checkbox"/> Pain with deep inhalation lying down | <input type="checkbox"/> Excessive phlegm (color?) |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Pneumonia                            |  |
| <input type="checkbox"/> Shortness of breath |   |  |

Any other lung problems

**DIGESTIVE**

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Belching        | <input type="checkbox"/> Rectal pain              |
| <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Black stools    | <input type="checkbox"/> Hemorrhoids              |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Indigestion     | <input type="checkbox"/> Chronic laxative use     |
| <input type="checkbox"/> Gas          | <input type="checkbox"/> Bad breath      |   |

Any other problems with stomach or intestines

**GENITOURINARY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Urgency to urinate   | <input type="checkbox"/> Decrease in flow  |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Impotence         |
| <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> Kidney stones        | <input type="checkbox"/> Sores on genitals |

Do you wake up at night to urinate?

If so, how often?

Any particular color to your urine?

Any other genital or urinary problems

**GYNECOLOGIC**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Premenstrual changes | <input type="checkbox"/> Heavy menstrual flow | <input type="checkbox"/> Premature births |
| <input type="checkbox"/> Menstrual clots      | <input type="checkbox"/> Light menstrual flow | <input type="checkbox"/> Miscarriages     |
| <input type="checkbox"/> Painful menses       | <input type="checkbox"/> Irregular menses     | <input type="checkbox"/> Abortions        |
| <input type="checkbox"/> Unusual menses       | <input type="checkbox"/> Cycle length-        |   |

Age at first menses Age at menopause Number of pregnancies

Do you use birth control? If so, what type? For how long?

Any other gynecologic problems

**MUSCULOSKELETAL**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Neck pain    | <input type="checkbox"/> Back pain        | <input type="checkbox"/> Hand/wrist pains |
| <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Muscle weakness  | <input type="checkbox"/> Shoulder pains   |
| <input type="checkbox"/> Knee pain    | <input type="checkbox"/> Foot/ankle pains | <input type="checkbox"/> Hip pain         |

Any other joint or bone problems

**PSYCHOLOGICAL**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Poor memory          | <input type="checkbox"/> Anxiety                      |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Bad temper                   |
| <input type="checkbox"/> Loss of balance   | <input type="checkbox"/> Concussion           | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression           |   |

Thank you for taking the time to fill out this health history form. We look forward to working with you.