JOVA ACUPUNCTURE
Weaving pathways for modern healing

DATE: M/ D/ YR/

INITIAL INTAKE FORM

ALL INFORMATION IS CONFIDENTIAL

PERSONAL INFORMATION			
Name:			
Date of birth:			
Age:	Height:	Weight:	Gender:
Street:		City: State:	Zip:
Cell phone:	cell carrier:		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

Main Concern(s):

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

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

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

If so, what is it?

What kinds of treatment or therapy have you tried?

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

Do you have history of fainting/seizures?

Are you on blood thiner medications (coumadin/warfarin)?

Are you pregnant?

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

- ☐ Allergies:
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease forceps delivery, etc.) trauma (describe)
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ Surgeries (describe)
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma (prolonged labor)
- ☐ Other significant illness
- ☐ Accidents

OTHER RELEVANT MEDICAL HISTORY

FAMILY MEDICAL HISTORY

☐ Allergies	☐ Cancer	☐ Seizures
☐ Diabetes	☐ Heart disease	☐ Stroke
☐ Asthma	☐ High blood pressure	☐ 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

☐ Poor appetite	☐ Weight gain	☐ Night sweats
☐ Insomnia	☐ Weight loss	☐ Fever
☐ Disturbed sleep	☐ Changes in appetite	☐ Chills
☐ Localized weakness	☐ Sweating easily	☐ Sudden energy drop
☐ Cravings	☐ Tremors (time of day?)	☐ Poor balance
☐ Strong thirst	☐ Bleeding/bruising easily	

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

SKIN & HAIR

☐ Rashes	☐ Eczema	☐ Recent moles
☐ Ulcerations	☐ Pimples	☐ Changes in texture of hair
☐ Hives	☐ Dandruff skin	
☐ Itching	☐ Hair loss	

Any other hair or skin problems

HEAD, EYES, EARS, NOSE, THROAT

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

Any other head or neck problems

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel problems

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Pain with deep inhalation lying down
- ☐ Pneumonia
- ☐ Difficulty breathing when
- ☐ Excessive phlegm (color?)

Any other lung problems

DIGESTIVE

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

Any other problems with stomach or intestines

GENITOURINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ 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

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Cycle length-
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions

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		
☐ Neck pain	☐ Back pain	☐ Hand/wrist pains
☐ Muscle pains	☐ Muscle weakness	☐ Shoulder pains
☐ Knee pain	☐ Foot/ankle pains	☐ Hip pain

Any other joint or bone problems

PSYCHOLOGICAL		
☐ Seizures	☐ Poor memory	☐ Anxiety
☐ Dizziness	☐ Lack of coordination	☐ Bad temper
☐ Loss of balance	☐ Concussion	☐ Easily susceptible to stress
☐ Areas of numbness	☐ Depression	

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