

Intake Form

Sandra L. Richard, MS, CA

| | |
|------------------|---------------------|
| Name _____ | Date _____ |
| Address _____ | Date of Birth _____ |
| _____ | E-mail _____ |
| Home Phone _____ | Referred by _____ |
| Work Phone _____ | Physician _____ |
| Cell Phone _____ | Dr's Address _____ |

Have you had acupuncture before? Y / N For what condition? _____

What do you want treated with acupuncture now? _____

How long have you had this condition? _____ Onset sudden / gradual

Symptoms are relieved by _____

Symptoms are made worse by _____

Medical diagnosis _____

Prescription Medications _____

Nutritional Supplements _____

In general, do you feel hot or cold? _____

Do you prefer hot or cold drinks? _____

Family Health History

| | Father | Mother | Sisters | Brothers | Children | Gr'mas | Gr'pas |
|-------------------------------|--------|--------|---------|----------|----------|--------|--------|
| Allergies | | | | | | | |
| Blood Disorder / Anemia | | | | | | | |
| Diabetes | | | | | | | |
| Cancer / Tumor | | | | | | | |
| Drug Abuse | | | | | | | |
| Heart Disease / Heart Attack | | | | | | | |
| High Blood Pressure | | | | | | | |
| Kidney / Bladder Disorder | | | | | | | |
| Psychiatric Condition | | | | | | | |
| Seizures | | | | | | | |
| Stomach / Intestinal Disorder | | | | | | | |
| Stroke | | | | | | | |
| Autoimmune Disorder | | | | | | | |
| Other: | | | | | | | |

Personal Health History

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Alcoholism / Drug Abuse | <input type="checkbox"/> Hepatitis A / B / C (circle) | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | List Allergens: |
| <input type="checkbox"/> Birth Trauma (Yours) | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Cancer / Tumors | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Problem | _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis | _____ |

List all previous surgeries (including removal of appendix / tonsils) and any major illnesses / injuries:

Approximate Date:

Event:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please indicate areas of tension, pain or discomfort:

Please locate and describe any headaches that you experience:

Circle those items, which you have currently.

Check those items, which you have had in the past.

Cardiovascular

- Chest pain / tightness
- High blood pressure
- Low blood pressure
- Palpitations
- Phlebitis
- Rapid heart beat

Emotions / Sleep

- Anxiety / panic attacks
- Depression
- Fatigued
- Frequent dreams / nightmares
- History of psychiatric treatment
- Insomnia
- Irritability
- Night sweating

Eyes / Ears

- Blurred vision
- Red / dry / itchy eyes
- See spots
- Ear infections
- Dizziness
- Ringing in ears
- Poor hearing

Female

- Breast lumps / disorders
- Clotting with menses
- Frequent vaginal infections
- Frequent vaginal discharge
- Irregular periods
- Light flow / heavy flow
- Menopausal symptoms
- Ovarian cysts
- Uterine fibroids
- Painful periods
- Premenstrual symptoms
- Avg. # of days in full cycle:
- Avg. # of days of menstruation:

Gastrointestinal

- Abdominal pain / bloating
- Acid reflux
- Belching / gas
- Blood in stool
- Constipation
- Diarrhea
- Food cravings
- Gallbladder disorder
- Hemorrhoids
- Hernia
- Nausea / vomiting
- Painful / hard stool
- Poor appetite
- Excess hunger
- Ulcer

Headaches

- At night
- During day
- Improved by rest
- Sharp
- Dull

Male

- Genital discharge
- Genital pain / itching
- Impotence
- Prostate condition

Musculoskeletal

- Abnormal spinal curve
- Backache
- Joint disorder / swelling
- Neck pain / stiffness
- Numb / tingling in limbs
- Repetitive strain
- Sore / tight muscles
- Spinal condition
- Spinal surgery
- Tendinitis

Nose / Throat / Mouth

- Bleeding gums
- Cold sores
- Frequent sore throat
- History of dental problems
- Sinus infections
- Thirsty
- No thirst
- Toothaches
- TMJ problem
- Oral herpes
- Oral surgery
- Do you smoke? Y / N
- When did you start?

Skin

- Acne
- Bruise easily
- Dry skin
- Eczema
- Hives / rashes
- Itchy skin
- Unusual sweating

Respiratory

- Asthma
- Chest constriction
- Chronic runny nose
- Chronic cough
- Cough with blood
- Cough with phlegm
- Dry cough
- Frequent colds

Urinary

- Burning urination
- Frequent urination
- Kidney stones
- Painful urination
- Weak stream
- Urinary tract infections