

Alliance Health Center Acupuncture Intake Form

Note: Information provided on this form is confidential

It is very important the information given is complete and accurate to assist you properly in your healing process.

Today's Date ___/___/___

How did you hear about us?

friend relative Ad healthcare referral Maricopa Event

Name _____ Date of Birth ___/___/___ Age:___ Sex: Male Female

Address _____

City/ State/ Zip _____

Telephone(home) _____ (work) _____ Occupation _____

Emergency Contact Person/Relationship _____

Phone# _____

Physician _____ Phone # _____

Health concerns you want treated with acupuncture? _____

How long have you had this condition? _____

The onset was: sudden gradual

Symptoms relieved by _____ Symptoms worsened by _____

What medical diagnosis have you received for this condition? _____

What other treatments have you received for this condition? _____

What medications are you taking? _____

For what condition(s)? _____

Most recent blood pressure reading? ___/___ Taken when? _____

Is this your first experience in Oriental Medicine and acupuncture? Yes No (please explain)

How do you feel about acupuncture? _____

Are you currently pregnant? Yes No

Are you presently trying to get pregnant? Yes No

Past Medical History:

Have you had any of this condition(s)? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Allergies (food, latex) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Addictions |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis A/B/C |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Joint Replacements |
| <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Lymph Nodes removed |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Surgeries/Hospitalizations _____ | |

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Exercise, Energy and Dietary:

How is your energy? _____

What time of day is your energy:

Highest? _____ Lowest? _____

Do you fatigue easily? _____

What kind of exercise do you do? _____

How often do you exercise? _____

Special Diet(?): _____ Water Intake _____

Emotions & Sleep:

How do you feel emotionally? _____

Do you have (check all that apply):

- Panic attacks Depression Anxiety Bad temper Nervousness
 Poor memory Difficult concentration

Are you in a relationship? Yes No

How do you feel about your relationship? _____

How do you hold stress? _____

How do you relax? _____

How do you feel about your work? _____

How long do you normally sleep? _____ hours per night

I have difficulties with (check all that apply): Falling asleep Staying asleep

Dream-disturbed sleep

Waking up at about _____ am/pm and not being able to fall asleep again

Gastrointestinal:

I have (check all that apply): Belching Nausea Vomiting Vomiting of blood

Ulcers Bloating Acid regurgitation Heartburn Hernia

Indigestion

Severe stomach pain

Bowel movements: How often? _____ time(s)/day _____ days/week

I have (check all that apply): Irregular Constipation Diarrhea Gas

Burning sensation Hemorrhoids Undigested food in stool Loose

stool Hard stool Blood in stool Itchiness Painful bowel

movements

Urinary:

Urination: How often? _____ times per day Color: Pale yellow Dark yellow/orange

I have or had (check all that apply): Trouble starting stream Frequent urination

Incontinence Pain Burning Dribbling when sneezing

Blood in urine Kidney stones Urinary tract infections

Other _____

Women:

At what age did you start menstruating? _____

Number of days between cycles: _____

Number of days of flow: _____ Color: _____

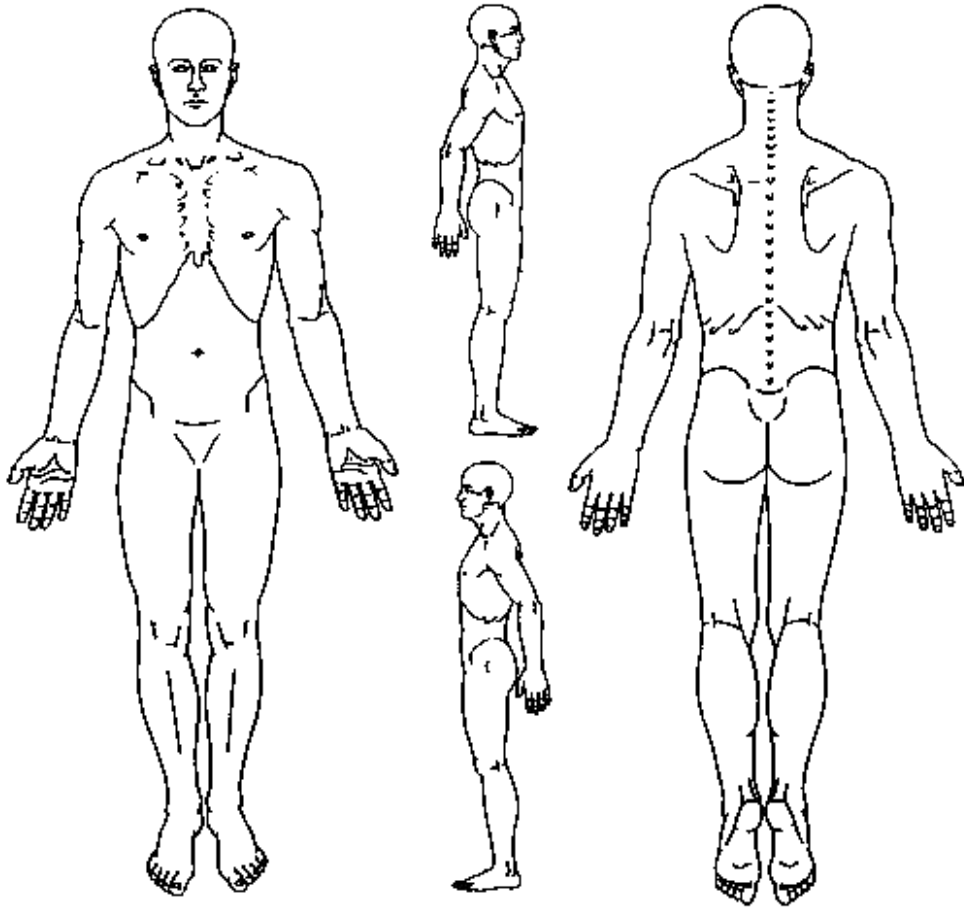
Number of Pregnancies _____ Miscarriages _____ Birth Control? _____

I have or had (check all that apply): Irregular menstruation Heavy flow Light flow No flow Clots Vaginal itching/burning Spotting between periods
 Discomfort/pain before period Discomfort/pain during period
 Other _____
 Any vaginal discharge? No Yes Color _____

Men:

I have (check all that apply): Prostatitis Impotence Penis blood/mucous discharge
 Other: _____

Pain Diagram (please mark all areas of pain on diagram below)
A=aching B=burning N=numbness P=pins and needles
S= stabbing pain O=other type of sensation



Muscles, Joints & Bones:

Do you have pain or tightness? No Yes Where? _____

The pain is (check all that apply): Sharp Dull Aching Numb
 Superficial Pain Deep Pain Burning Tingling
Shooting Pain worse/better with heat Pain worse/better with cold
 Pain worse/better with pressure Pain worse in am/pm

I have (check all that apply): Swollen joints Arthritis/joint pain
Tendonitis Bone pain Muscle cramping Muscle pain Repetitive
Strain Injury
 Fractured Bone(s) -- Where? _____
 Other _____

Eyes, Ears, Nose, Throat, & Head:

Do you smoke? No Yes _____ per day, for _____ years

I have (check all that apply): Frequent colds Chronic runny nose Frequent sore
throat Chronic cough Coughing blood Cough up mucous Pain
inhaling Shortness of breath on exertion/at rest Asthma
Nose bleeds
 Painful/red eyes Poor vision See spots/floaters
 Dizziness Cold sores Bleeding gums Dry
mouth
 Ear pain Ringing in ears Clogged/popping in ears
 Frequent headaches/migraines: Describe: _____

Cardiovascular:

I have (check all that apply): Chest pain Palpitation Varicose
veins Phlebitis Cold hands and feet Irregular heart beat
 Poor circulation Other: _____

Skin & Hair:

I have or often have (check all that apply): Dry skin Skin rashes
Itching
 Acne Eczema Hives Hair loss
 Premature graying Other: _____