Healing Care Acupuncture

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Patient Intake Form

Please help me to provide you with the best possible care by taking the time to fill out this form as accurately as you can. All information provided is confidential. Please feel free to ask if you have any questions. Thank you.

Name _____ Date _____ Gender: F☐ M☐ Married☐ Single☐ Other☐
Date of Birth _____ Age_____ Height _____Weight _____
Address _____ Home Phone (___)_____
City _____ Mobile Phone (___)_____
State _____ Zip Code _____Email _____Work Phone (___)_____
Occupation_____ Employer _____
Emergency Contact _____ Phone _____ Relationship _____

Primary Physician _____ Phone _____ Referred by _____
Main reason you are seeking acupuncture _____
Have you been given a diagnosis for this problem? _____What was the diagnosis? _____
How long have you had this problem? _____
What kinds of treatments have you tried? _____
Have you been treated by acupuncture before?_____

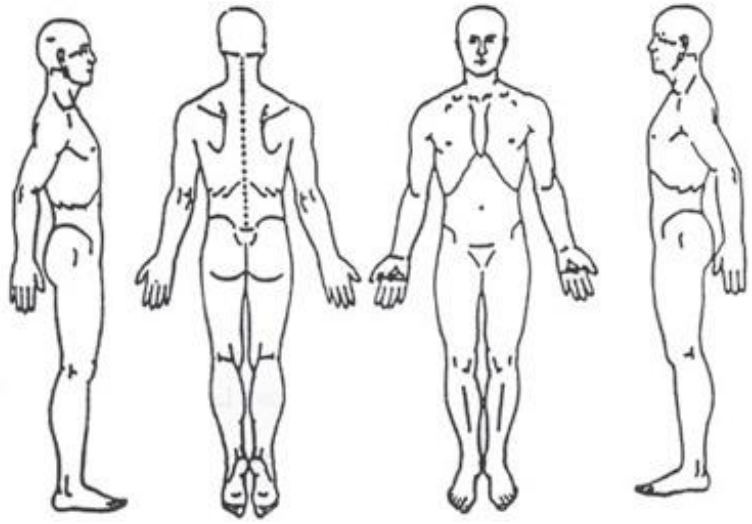
Family History

Mother's Side _____
Father's Side _____
Siblings _____
If any of the above is deceased, what was the cause? _____

Personal Lifestyle Habits

Coffee/Tea (cups per day) _____ Cigarettes (packs per day) _____
Soda (regular or diet) _____ Alcohol (drinks per week) _____
Exercise (how often) _____ Drug use (recreational) _____
Current Predominant Emotion _____ Stress level: Low:☐ Moderate:☐ High:☐
Best time of year _____ Energy level: Low:☐ Moderate:☐ High:☐

Please indicate on the diagram any type of pain or injury and describe _____
Circle all that applies: Sharp Numb Dull Stabbing Aching Burning **Better with:** Heat Cold Pressure



Please describe any medical devices or implants and indicate on the diagram
_____
_____
_____
_____
_____

Past Medical History

Please indicate/describe all that applies if you have experienced in the Past (P) and Currently (C) any of the following:

Significant Illnesses

____ AIDS/HIV
____ Alcoholism
____ Allergies (medications, foods, latex)_____
____ Bleeding disorders_____
____ Cancer _____
____ Diabetes
____ Fibromyalgia
____ Hepatitis Type ___
____ Herpes Type ___
____ High cholesterol
____ Multiple Sclerosis
____ Rheumatic fever
____ Stroke
____ STD_____
____ Thyroid disorders
____ Tuberculosis
____ Other _____

General

____ Insomnia/Poor sleep
____ Dreams-disturbed sleep
____ Difficulty falling asleep
____ Difficulty staying asleep
____ Hours of sleep_____
____ Fatigue
____ Recent weight loss/gain
____ Strongly like cold drinks
____ Strongly like hot drinks
____ Tendency to be cold
____ Tendency to be warm
____ Sweat easily
____ Night sweats
____ Chills
____ Fever
____ Sudden energy drops
____ Peculiar tastes or smell
____ Other _____

Head and Neck

____ Headaches
____ Migraines
____ Stiff neck
____ Swollen glands
____ Other _____

Ears

____ Hearing aids
____ Hearing loss: L_ R_ Both_
____ Ringing: L_R_ Both _
____ Earache
____ Ear infection
____ Ear drainage
____ Other _____

Eyes

____ Glasses/contact lenses
____ Blurred vision
____ Poor night vision
____ Spots or floaters
____ Eye inflammation
____ Double vision
____ Glaucoma
____ Cataracts
____ "Lazy" eye
____ Itchy eyes
____ Dry eyes
____ Excessive tearing
____ Eye pain
____ Eye strain
____ How often checked?_____
____ Other _____

Nose, Throat, and Mouth

____ Sinus problems
____ Hay fever/allergies
____ Frequent colds
____ Frequent sore throat
____ Difficulty swallowing
____ Sores on lips, tongue, mouth
____ Nosebleed
____ Dry nose
____ Nasal drainage
____ Nasal congestion
____ Hoarseness
____ Thirst
____ Excessive saliva
____ Facial pain
____ Dry mouth
____ Dental problems
____ Grinding teeth
____ Other _____

Skin

____ Hives
____ Rashes
____ Eczema
____ Dry skin
____ Itching
____ Bruise easily
____ Acne
____ Other _____

Respiratory

____ Difficulty breathing
____ Difficulty when reclining
____ Asthma
____ Chronic cough
____ Coughing up phlegm
____ Coughing up blood
____ Shortness of breath
____ Pneumonia
____ Other _____

Cardiovascular

____ High blood pressure
____ Low blood pressure
____ Chest pain or tightness
____ Palpitation
____ Rapid heart beat
____ Irregular heart beat
____ Poor circulation
____ Cold hands and feet
____ Swollen hands and feet
____ Swollen ankle
____ Phlebitis
____ Varicose veins
____ Anemia
____ History of heart disease
____ Heart murmur
____ Other _____

Gastrointestinal

____ Cravings_____
____ Bad breath
____ Nausea
____ Indigestion
____ Stomach pain
____ Abdominal pain
____ Gallbladder problems
____ Hernia
____ Diarrhea
____ Loose stools
____ Constipation
____ Poor appetite
____ Excessive hunger
____ Vomiting
____ Bloating
____ Gas
____ Hiccups
____ Acid reflux
____ Hemorrhoids
____ Bloody stool
____ Bowel movements
____ x per day
____ Other _____

Musculoskeletal

____ Joint pain/swelling_____
____ Arthritis
____ Muscle cramps
____ Muscle weakness
____ Muscle soreness
____ Herniated disc
____ Osteoporosis
____ Pain (see diagram)
____ Injury (see diagram)
____ Other _____

Neurological
____ Concussions
____ Fainting
____ Dizziness
____ Seizures
____ Tremors
____ Numbness or tingling
____ Paralysis
____ Poor coordination/balance
____ Vertigo
____ Poor memory
____ Other _____

Mental/Emotional
____ Depression
____ Mood swings
____ Irritability
____ Easily angered
____ Panic attacks
____ Difficulty relaxing
____ Difficulty making decisions
____ Loneliness
____ Sadness
____ Sensitive
____ Shyness
____ Nervousness
____ Frequent crying
____ Frequent worrying
____ Compulsive behaviors
____ Difficulty focusing
____ Hopelessness
____ Suicidal thoughts
____ Frustration
____ PTSD
____ Other _____

Urinary
____ Pain with urination
____ Frequent/urgent urination
____ Incomplete urination
____ Incontinence
____ Bedwetting
____ Waking to urinate___ x night
____ Blood in urine
____ Cloudy urine
____ History of UTI
____ Bladder infections
____ Kidney problems
____ Other _____

Male Genital
____ Fertility problems
____ Impotence
____ Premature ejaculation
____ Nocturnal emission
____ Groin pain
____ Pain/itching of genitalia
____ Prostate problems
____ Increased libido
____ Decreased libido
____ Other _____

Gynecology (Women Only)
____ Fertility problems
____ Currently pregnant
____ # of Pregnancies
____ # of Live births
____ # of Caesarian births
____ # of Miscarriages
____ # of Abortions
____ Menopause
____ Bearing down sensation
____ Last menstrual period_____
____ Birth control_____
____ PMS
____ Missed/Irregular periods
____ Menstrual cramps
____ Excessive blood flow
____ Menstrual blood clots
____ Breast tenderness
____ Abnormal pap smear
____ Vaginal infections
____ Vaginal pain/itching
____ Vaginal dryness
____ Uterine fibroids
____ Ovarian cysts
____ Endometriosis
____ Breast lumps, cysts
____ Increased libido
____ Decreased libido
____ Other _____

Surgeries (type and date)
_____
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Trauma, Injuries (type and date)
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Medications, Supplements, and Vitamins (dosage and for what condition)
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Other information
_____
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_____

Acupuncture Clinic Fees
First Visit Clinic Fee
Traditional Chinese Medicine
Diagnosis and Treatment $100.00

Follow-up Visit Clinic Fee
Treatment $85.00

All payments are due at time of service. Accepted payments include cash, checks, and credit cards.

Appointment Reminders
Healing Care Acupuncture understands that it is not always possible to keep scheduled appointments. In order to help reduce Late Cancellation or
No Show, please indicate how you would like to be reminded of your appointment:
□ Phone Call: _____
□ Text: _____
□ Email: _____

_____
Signature of Patient or Legal Representative

_____
Date