Acupuncture Atelier

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Initial Intake Form

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential.

Today's Date _____/_____/_____

General Information

Name ______________________________ Birthdate _____/_____/_____ Age ________ Gender (circle) **M** **F**

Address ______________________________ City ____________________ State ________ Zip ____________

Email Address ______________________________ Home Phone ______________ Cell ______________________ Work Phone ______________

Marital Status ______________ Occupation ________________ Employer ______________________________

Emergency Contact _______________ Phone ______________ Relationship ________________

Primary Care ____________________ Phone ______________ Last Physical _____/_____

OB-GYN ______________________ Last PAP ____/_____ Specialist(s) ____________________________

Insurance Provider ________________________

Policy/ID #______________________________

Group # ______________________________

May I contact these providers to ensure integrated care? (circle) **Y** **N** Height ______________ Weight ____________

How did you hear about us? ____

Health Concern(s)

What brings you here today? ____

____

____

How long have you been experiencing the condition? ____________________________ Physician Diagnosis? ____________________________

Is there a specific event that correlates to your condition? ____

____

Are you in pain today? (circle) **Y** **N** What number best describes your pain today? (0 = no pain, 10 = severe) ___________

Is your condition affected by seasonal changes? **Y** **N** Describe the quality of pain ______________________________

Medication for this condition(dosage)? ____

Does the medication help? ______________________________

What improves your condition? ______________________________

What makes your condition worse? ______________________________

Is your condition consistent or come and go? ______________________________

Does this condition affect your emotional health? ______________________________

Are you currently in therapy? ______________________________

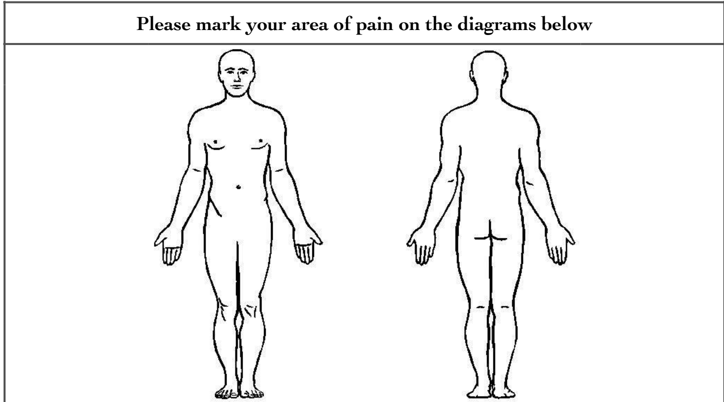
What would you describe your general level of stress? ______________________________

Anything else to note? ______________________________

Any other conditions you would like addressed? ______________________________

____

Please mark your area of pain on the diagrams below



Health History

Any birth trauma? **Y** **N**

If yes, please explain ______________________________

Any childhood illnesses? ______________________________

____

Allergies?______________________________

Scars? ______________________________

Please list any current Medications, Herbs, Supplements:

Name ____________________ Reason ____________________ Dose _______

Name ____________________ Reason ____________________ Dose _______

Name ____________________ Reason ____________________ Dose _______

Name ____________________ Reason ____________________ Dose _______

Name ____________________ Reason ____________________ Dose _______

Please list and indicate the approximate date of any serious disease, injuries, surgeries, or hospitalizations:

Condition ________________________ Date ____/____ Age _______ Condition _____________________________ Date ___/____ Age _______

Condition ________________________ Date ____/____ Age _______ Condition _____________________________ Date ___/____ Age _______

Condition ________________________ Date ____/____ Age _______ Condition _____________________________ Date ___/____ Age _______

Family History (Please list any family physical or mental illnesses and age of death)

Mother ____

Father ____

Maternal Grandparents ____

Paternal Grandparents ____

Siblings ____

Past Medical History (circle all that apply)

Alcoholism	Fibromyalgia	Lyme's Disease	Sinus Infections
Arthritis/ Rheumatism	Heart Disease	Lymph Nodes Removed	Skin Disease
Asthma	Hepatitis	Mental Illness	Special Diet
Attempted Suicide	Herpes	Multiple Sclerosis	Stroke
Bleeding Disorder	High Blood Pressure	Pacemaker	Substance Abuse
Blood Disease	HIV/ AIDS	Polio	Thyroid Disease
Cancer/ Tumor	Immune Disorder	Rheumatic Fever	Tuberculosis
Diabetes	Joint Replacement	Sciatica	Ulcer
Emphysema	Kidney Disorder	Scarlet Fever	Venereal Disease/ STD
Eating Disorder	Low Blood Pressure	Seizures/ Epilepsy	Other

Lifestyle Habits

Please describe your typical daily diet below

Breakfast ____ Lunch _________________________________ Dinner ____________________________________

Do you drink coffee? **Y N** How many cups daily? _______ Do you drink soda? **Y N** How many cups daily? ________

Do you smoke cigarettes? **Y N** How long? __________ How many packs? _________ Do you use recreational drugs? **Y N**

Do you drink alcohol? **Y N** How many drinks a week? __________ Do you think this is a problem? **Y N**

Do you exercise? **Y N** If yes, how often? _________________________ How many hours of sleep do you get a night?___________

Please list any goals for your health ____

General Health (circle current conditions, check mark past conditions)

Poor Appetite	Cold Feet and Hands	Thrist	Chills
Disturbed Sleep	Night Sweats	Weight Loss	Catches Colds Easily
Insomnia	Cold Abdomen	Fevers	Sudden Energy Drop
Fatigue	Tremors	Bruise/Bleed Easily	Soft/Brittle Nails
Poor Coordination	Large Appetite	Sweat Easily	Cravings ________________
Weight Gain	General Weakness	Poor Balance	

Skin and Hair Health (circle current conditions, check mark past conditions)

Rashes	Dandruff	Redness/ Rosacea	Acne
Itching	Ulcerations	Eczema	Recent Moles
Psoriasis	Hair Loss	Hives	

Head, Eyes, Ears, Nose, Throat Health (circle current conditions, check mark past conditions)

Dizziness	Night Blindness	Headaches	Dry Mouth/Throat
Eye Pain	Ringing in Ears	Migraines	Bleeding Gums
Blurred Vision	Poor Hearing	Recurrent Sore Throat	Nosebleeds
Floaters in the Eyes	Ear Aches	Lip/Tongue Sores	Other (specify) ______________
Jaw Clicking	Toothaches/Pain	Facial Pain	

Cardiovascular Health (circle current conditions, check mark past conditions)

Low Blood Pressure	Fainting	Blood Clots	Swelling of Hands/Feet
High Blood Pressure	Chest Pain	Palpitations	Irregular Heart Beat

Respiratory Health (circle current conditions, check mark past conditions)

Cough	Bronchitis	Pain with Deep Breath	Trouble Breathing while Lying Down
Coughing Blood	Pneumonia	Shortness of Breath	Other (specify) ______________
Asthma	Coughing Phlegm	Nasal Congestion	

Gastrointestinal/ Abdominal Health (circle current conditions, check mark past conditions)

Nausea	Bloating	Retention of Food	Blood in Stool
Vomiting	Belching	Lack of Appetite	Hemorrhoids
Diarrhea	Abdominal Pain/Cramps	Excess Appetite	Bad Breath
Constipation	Indigestion	Rectal Pain	Sensitive Abdomen
Gas	Heartburn/ Reflux	Black Stools	Chronic Laxative Use

Urinary and Genital Health (circle current conditions, check mark past conditions)

Urinary Pain	Urgency to Urinate	Decrease in Flow	Waking at Night to Urinate
Frequent Urination	Unable to Hold Urine	Impotence	How many times?
Blood in Urine	Kidney Stones	Sores on Genitals	Other (specify) ______________

Musculoskeletal Health (circle current conditions, check mark past conditions)

Neck Pain	Foot/Ankle Pain	Sciatica	Joint Pain
Back Pain	Shoulder Pain	Muscle Weakness	Bone Problems
Knee Pain	Hip Pain	Hand/Wrist Pain	Muscle Pain

Psychological and Neurological Health (circle current conditions, check mark past conditions)

Seizures	Areas of Numbness	Concussion	Bad Temper
Dizziness	Poor Memory	Depression	Easily Stressed
Loss of Balance	Lack of Coordination	Anxiety	Suicide Attempt
Mania	Panic Attacks	Seasonal Depression	Mood Swings

Autoimmune and Inflammatory Conditions (circle current conditions, check mark past conditions)

Hashimoto's Disease	Colitis	Allergy	Neurodermatitis
Rheumatism	Crohn's	Food Allergy	Cellulitis
Lupus	Alopecia (baldness)	Atopic Dermatitis	Sinus Infections

Allergy Health (circle current conditions, check mark past conditions)

Animal Products/Gelatin	Honey	Fermented Products	Soy
Citrus	Pollen	Shellfish	Talc
Wheat	Grass	Other:	

Sleep Health (circle current conditions, check mark past conditions)

How many hours of sleep per night do you get? ____________________

Can't Fall Asleep	Tossing and Turning/Restless Sleep	Sleep Apnea	Trouble Waking
Once Asleep, Stays Asleep	Excess Dreaming	Violent Dreams	Not Feeling Rested
Wakes Easily	Grinds Teeth in Sleep	Fatigue After Eating	Other

Female Gynecological Health (fill out and circle current conditions, check mark past conditions)

Are you pregnant? **Y N**	Trying to conceive? **Y N**	Trouble conceiving? **Y N**		
Age of 1st Period _______	Age at menopause ________	# of Pregnancies ______	# of Live Births _______	Caesarian? **Y N**
# of Premature Births_______	# of Miscarriages ________	# of Abortions ________	# of days between periods _______	
# of flow days ______	Color of Blood ___________	Clots? **Y N**	Date of Last Period ____/____	

Painful Periods	Strong Menstrual Odor	Vaginal Dryness	Hot Flashes
Irregular Menses	Vaginal Discharge	Fibroids	Decreased Libido
PMS	Vaginal Odor	Breast Lumps/Swelling	Sexual Transmitted Disease _________________
Endometriosis	Ovarian Cysts	Urinary Tract Infection	Vulvodynia/Vulvavestibulitis
Unexplained Pelvic Pain	Pelvic Floor Dysfunction	Yeast Infection	Other (specify) ___________________________

Male Health (circle current conditions, check mark past conditions)

Erectile Dysfunction Pelvic Floor Dysfunction Sexual Transmitted Disease _______________

Decrease Libido Painful Intercourse Other (specify) __________________________

Have you traveled out of the country within the past year? **Y** **N** If so, where? ____

How's your working environment? ____

How's your home life? ____

Any additional comments or concerns?____

The information that I have documents on this form is accurate and I will advise the practitioner of any changes in my health or changes in my medications, nutritional supplements and dietary habits.

Signature of Patient ____ **Date** ______________________

Signature of Guardian (patient under 18 years) ____ **Date** ______________________

Signature of Practitioner ____ **Date** ______________________