

# Intake Form

Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City, ST ZIP \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Date of Birth \_\_\_\_\_ (Age) \_\_\_\_\_

Marital Status: (M, S, W, D) \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_

Physician: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_

Physician's Diagnosis \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Allergies \_\_\_\_\_

1. Have you ever had acupuncture before? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Have you eaten today? \_\_\_\_\_

a. If so, at what time was your last meal? \_\_\_\_\_

3. What is the problem that brought you here today? \_\_\_\_\_

4. Has there been anything that has ever been able to change your problem in any way?

a. If so, please describe. \_\_\_\_\_

5. When did this problem first appear? \_\_\_\_\_

6. Is it constant or does it come and go? \_\_\_\_\_

7. If applicable, does the problem ever move? (For example, pain or spasms that occur in different joints or muscles at different times) \_\_\_\_\_

8. If applicable, is the pain sharp or dull? \_\_\_\_\_

9. What makes your pain better? Please circle all that apply.

- Heat
- Pressure
- Movement
- Cold
- Massage
- Rest

Describe any other ways in which your pain is made better. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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10. Is your illness affected by seasonal changes? Please describe. \_\_\_\_\_  
\_\_\_\_\_

11. Are there other problems you would like addressed? \_\_\_\_\_  
\_\_\_\_\_

12. Are you currently on any medications? Please list. \_\_\_\_\_  
\_\_\_\_\_

13. Do you take any vitamins/supplements? Please list. \_\_\_\_\_  
\_\_\_\_\_

14. Have you had any surgeries? If yes, what type of surgery and when did you have it done? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. History of Significant Illness:

**Self:** (Please include all past accidents, childhood illnesses, and the date that they occurred)

\_\_\_\_\_  
\_\_\_\_\_

**Mother:** \_\_\_\_\_  
\_\_\_\_\_

**Father:** \_\_\_\_\_  
\_\_\_\_\_

**Maternal Grandmother/Grandfather:** \_\_\_\_\_  
\_\_\_\_\_

**Paternal Grandmother/Grandfather:** \_\_\_\_\_  
\_\_\_\_\_

15. Do you smoke? If yes,

a. the number of cigarettes you smoke daily? \_\_\_\_\_

b. the number of packs you smoke daily? \_\_\_\_\_

16. Do you drink alcohol? If yes,

a. how many glasses per day? \_\_\_\_\_

b. how many glasses per week? \_\_\_\_\_

c. how many glasses per month? \_\_\_\_\_

17. Describe your sleep habits (for example, number of hours per night that you sleep, do you have trouble falling to sleep, or do you awake very early and are then unable to go back to sleep) \_\_\_\_\_  
\_\_\_\_\_

18. Describe your bowel habits (regular, constipation, diarrhea) \_\_\_\_\_

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19. If you suffer from constipation,
- a. do you feel better or worse immediately after moving your bowels? \_\_\_\_\_
  - b. how many days pass before you move your bowels? \_\_\_\_\_
20. If you suffer from diarrhea,
- a. does it occur early in the morning when you first wake up? \_\_\_\_\_
  - b. does your rectum burn as the stool exits? \_\_\_\_\_
  - c. how many episodes of diarrhea do you have per day? \_\_\_\_\_
21. Do you regularly experience abdominal pain? \_\_\_\_\_
- a. If yes, what makes it better? Please circle all that apply.  
Heat / Cold    Eating / Not Eating    Rest / Movement    Massage    Other
22. Do you have any emotional difficulties? Please circle all that apply.
- a. Anxiety
  - b. Panic Attacks
  - c. Depression
  - d. Mania
  - e. Mood Swings
  - f. Seasonal Affective Disorder
23. How would you rate your ability to concentrate/maintain focused thinking, and have clarity of thought? Please circle one choice.
- Excellent                  Good                  Fair                  Poor
24. How many times a day do you urinate? \_\_\_\_\_
- a. Is your urine: Clear and scant / abundant or Dark and scant / abundant
25. How would you rate your appetite? Please circle one choice.
- Excessive                  Moderate/Good                  Poor
26. Do you crave sweets? \_\_\_\_\_
- a. Do you crave other foods? If yes, what type? \_\_\_\_\_
27. Do you get headaches often? \_\_\_\_\_
- a. If yes, is the headache always in the same location? \_\_\_\_\_  
Where? \_\_\_\_\_
28. Do you ever experience dizziness? \_\_\_\_\_
29. Are you often thirsty? \_\_\_\_\_
30. Do you prefer cold or warm drinks? \_\_\_\_\_
31. Do you often feel cold? \_\_\_\_\_
- a. If yes, where? Please circle all that apply.  
Hands / Feet                  Limbs                  Entire Body                  Other
32. Describe the degree to which you sweat:
- Very Little                  Average                  Excessive

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33. Do you exercise? If yes, how often?

What do you do? \_\_\_\_\_

34. How would you rate your energy level?

Excellent                  Good                  Fair                  Poor                  Other

35. Describe your diet:

a. Number of vegetable portions eaten daily \_\_\_\_\_

b. Number of meat product portions eaten daily \_\_\_\_\_

c. Number of dairy product portions eaten daily \_\_\_\_\_

d. Number of caffeine containing products eaten daily \_\_\_\_\_

e. Number of whole grain product portions eaten daily \_\_\_\_\_

36. Have you had your lymph nodes removed? If yes, please describe. \_\_\_\_\_

37. Do you have any infectious diseases? \_\_\_\_\_

38. Do you have a history of drug abuse? \_\_\_\_\_

## WOMEN ONLY

39. Is there a chance that you could be pregnant? \_\_\_\_\_

40. Are your menstrual cycles:      Regular                  Irregular                  Early                  Late

41. Is your menstrual flow:                  Heavy                  Normal                  Light

42. Is the blood: Normal                  Purplish                  Dark                  Light

43. Does your menstrual blood contain clots? \_\_\_\_\_

44. Is your vaginal discharge: Clear/White and thin      Yellow and Thick

45. Do you have itching or soreness of the vagina? \_\_\_\_\_

46. If you generally experience mood swings, use the choices below to describe how they are around the time of your menses. Please circle one.      Better                  Worse                  Same                  Not Applicable

47. Number of children \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

Number of abortions \_\_\_\_\_

Reviewed by:

Student's Printed Name \_\_\_\_\_ Student's Signature \_\_\_\_\_

Supervisor's Printed Name \_\_\_\_\_ Supervisor's Signature \_\_\_\_\_

Date: \_\_\_\_\_