Tri Acupuncture

Acupuncture Full Intake Form

Patient Name: _____ Date of birth_____
Home Address: _____
Phone: Cell: _____Home:_____
Email: _____
Marital status: _____M____S____D ___W Occupation: _____
Emergency Contact: _____ Phone:_____
Relationship to the patient_____
Physician's Name: _____Phone:_____

Will medical records need to be released to attorneys? Yes No

MEDICATIONS AND SUPPLEMENTS

List medication and supplements you are currently taking

_____

ALLERGIES to medications or substances

_____

What is the problem that brought you here today? _____

_____

What is the physician's diagnosis?

_____

When did the problem start? _____
What was the initial cause? _____
What makes it worse? _____
What makes it better? _____
Did this problem interfere with your daily activities? (Please circle all that apply)
Sleep Work Walking Sitting Standing Bending Stretching
Emotional Social Life Recreation Sexually Other_____

Musculoskeletal: Neck pain/ **S**houlder pain/ **B**ack pain/ **H**and or **w**rist pain/ **H**ip pain/ **K**nee pain/ **Foot** or **a**nkle pain/ **S**ciatica /**M**uscle pain/ **M**uscle Weakness

IF PAIN please describe below:
Pain Location: _____ Pain quality: _____
How often: _____

What have you done about this? _____
What treatments did you get about this? _____
What are your health goals? _____
List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.)_____

HOSPITALIZATIONS and SURGERIES

_____

Do you have any scars? (Note location of all operations or injury scars, even minor ones)

_____

Is this your first time to try acupuncture? Yes // No
How did you hear about us? _____

General Health (please circle all that apply):

- **Body temperature**: **C**old hands or feet / **C**old abdomen / **F**ever / **E**asily sweating during daytime / **N**ight Sweats _____
- **Cravings**: **S**weet / **S**our / **S**picy / **S**alty / **B**itter
- **Appetite: L**arge appetite / **P**oor appetite / **H**ungry but can't eat / **C**ommonly hiccups
- **Thirsty_____/ No thirst_____ / Daily _____**ounces of water
- **Bowel movement: F**ormed / **L**oose / **D**iarrhea/ **D**ry / **H**ard / **B**ig size / **S**mall size / **O**nce / **T**wice / **T**hird / **M**orning / **N**oon / **N**ight
- **Urine: C**olor_____ **/ A**mount_____ / **F**requency_____ / **U**rination at night _____
- **Sleep: E**asy or **D**ifficult falling asleep **/ D**reamless / **M**ulti-dream **/** Sleep hours: _____
- **W**eight Loss / **W**eight Gain / **W**eakness / **S**trong / **P**oor Balance
- **Catches Colds Easily** / Other (please specify):_____
- **Easily bruises / bleeds**_____
- **MEN ONLY: P**rostate Enlargement **/E**rection Difficulties **/** /**P**remature ejaculation/ **I**mpotence / **N**octurnal Emission
  Other:_____
- **WOMEN ONLY**:

Are you Pregnant? __ Yes / __ No Trying to conceive? __ Yes / __ No
Problems with conception? __ Yes __ No Age of 1st Period_____
Age at menopause_____ # of Pregnancies ____ # of live births_____
# of premature births ____ # of Miscarriages/Abortions_____
# of days between periods____ # of days of flow_____
__ Breast Lump/Swelling __ Hot Flashes __ Nipple Discharge __ Vaginal Discharge
__ Painful Intercourse __ Abnormal Pap Smear __ Painful menses
__ Irregular menses __ Vaginal Odor __ Fibroids __ Ovarian Cysts
__ Sexually Transmitted Disease __ Vaginal Dryness __ Decreased Sex Drive
__ Strong menstrual odor __ Urinary Tract Infection __ Premenstrual symptoms
Other:_____

Family Medical History (circle all which apply & specify which blood relative- parents, grandparents, siblings)

Cancer / **H**igh Blood Pressure /**H**igh Blood Cholesterol/ **D**iabetes/ **H**epatitis / **S**eizures / **E**motional Disorder / **T**uberculosis
Other (please specify):_____

The information that I have documented on this form is accurate and I will advise the practitioner of any changes in my health or changed in my medications, nutritional supplements, and dietary habits. I will not hold my doctor or any members of his and her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____Date:_____
Signature of Practitioner: _____Date:_____