



Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date
Date of birth	Age	Occupation
Main phone #	Other phone #	
E-mail address	Allow email contact by One Clinic Express <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency contact name & phone	Marital status	# of children
Address: Street	City	State
		Zip
Family physician	Chiropractor	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of insurance company _____		
Does your insurance cover acupuncture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ? Have you ever been treated by acupuncture before? _____		
How did you find out about our clinic? <input type="checkbox"/> Friends/Relatives(name) _____		
<input type="checkbox"/> Direct mail <input type="checkbox"/> Location or walk by <input type="checkbox"/> Website <input type="checkbox"/> Referred by _____		
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Periodicals <input type="checkbox"/> Other (please specify) _____		

Main problem(s): _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____ What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____ Remarks and additional information:

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: _____ **Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental): _____

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

Occupation : _____ Do you usually work indoors outdoors?
 Occupational stress (chemical, physical, psychological, etc): _____

Personal Height _____ Weight now _____ Weight one year ago _____
 Weight maximum _____ @Year _____

Habits Do you smoke ? Yes No What? _____ How many per day? _____ Since when? _____
 Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly Yes No Please describe your exercise program: _____

How many hours do you sleep in general? _____ When time do you usually go to bed? _____

Diet How much coffee do you drink? _____ cups/day Colas _____ number/day Tea _____ cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? Yes No Yes, but not so strict Do you eat a lot of spicy food? Yes No

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

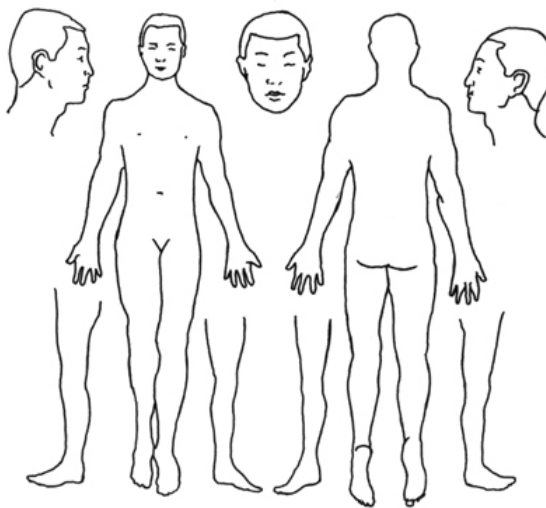
Morning _ _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

- General** Poor appetite Poor sleep Fatigue Fevers Chills
 Night sweats Sweat easily Tremors Cravings Change in appetite
 Poor balance Bleed or bruise easily Localized weakness Weight loss Weight gain
 Peculiar tastes Desire hot food Desire cold food Strong thirst (cold or hot drinks)
 Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair Rashes Ulcerations Hives Itching Eczema
 Pimples Acne Dandruff Dry skin Recent moles Loss of hair
 Purpura Change in hair or skin texture Other?

Musculoskeletal Joint disorders Muscle weakness Pain/soreness in the muscles Tremors
 Cold hands/feet Difficulty walking Swelling of hands/feet Spinal curvature Back pain Hernia
 Numbness Tingling Paralysis Neck tightness Neck pain Shoulder pain
 Hand/wrist pain Hip pain Knee pain Joint Sprain Other?

Head, eyes, ears, nose, and throat Dizziness Concussions Migraines Glasses/lens
 Eye strain Eye pain Color blindness Night blindness Poor vision Cataracts
 Blurry vision Earaches Ringing in ears Poor hearing Spots in front of eyes
 Sinus problems Nose bleeding Sore throat Grinding teeth Teeth problems Facial pain
 Jaw clicks Sores on lips/tongue Difficulty swallowing Other?

Cardiovascular High blood pressure Low blood pressure Chest pain Palpitation Fainting
 Phlebitis Irregular heartbeat Rapid heartbeat Varicose veins Other?

Respiratory Cough Coughing blood Wheezing Difficulty breathing
 Bronchitis Pneumonia Chest pain Production of phlegm – What color? _____

Gastrointestinal Nausea Vomiting Diarrhea Constipation Gas
 Belching Black stools Blood in stools Indigestion Bad breath Rectal pain
 Hemorrhoids Abdominal pain/cramps Gallbladder problems Parasites Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological Loss of balance Lack of coordination Concussion
 Depression Anxiety Stress Bad temper Bi-polar

Genito-urinary Painful urination Frequent urination Blood in urine Urgency to urinate
 Kidney stones Unable to hold urine Dribbling Pause of flow Frequent urinary tract infection
 Genital pain Genital itching Genital rashes STD Other?

Female Frequent vaginal infections Pelvic infection Endometriosis Vaginal/genital discharge
 Fibroids Ovarian cysts Irregular periods Clots Pain/cramps prior/during periods
 Breast tenderness Breast Lumps Fertility Problems Hot flashes Moodiness related to periods
_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions
_____ Premature births _____ C-section _____ Difficult delivery
First date of last period _____ Age of first period _____ Duration of periods _____ days, cycle ____ days
Do you practice birth control ? Yes No. If yes, what type and for how long? _____
If you're on birth control pills, what are you taking and for how long? _____

Male Prostate problems Discharge Erectile dysfunction Ejaculation problems
 Frequent seminal emission Fertility problems Painful/swollen testicles Other

I have completed this form correctly to the best of my knowledge.

Signature: Adult Patient Parent or Guardian Spouse

Are there any other health issues you want to discuss with us?

Signature

Date