A. Brand
of Acupuncture

Patient Intake Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name _____ Sex M ___ F___ Date _____ Email _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____Place of birth _____ Age _____ Height _____ Weight_____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

_____ Single _____ Married _____ Divorced _____ Widowed _____ Living with

Education _____ Occupation _____

Referred by: _____

Reason for visit today _____

Other problems _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep ___Work ___other (what?) _____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Vitamins & herbs _____

Dietary restrictions _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) _____

_____

MEDICINES:

Prescription drugs you are currently taking: For what condition?

_____ _____
_____ _____
_____ _____
_____ _____

Over-the-counter medication you are currently taking: For what condition?

_____ _____
_____ _____
_____ _____

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: _____

Name & address of physician _____

Phone number of physician _____

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes No

GYNECOLOGY

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow _____

Blood clots: yesnowhen: _____ Length of cycle _____

Color of menstrual blood:palebright reddark redbrown other _____

Texture of menstrual blood: thickthinwaterynormal

Pain: yesnowhen: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant?yesno

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear:normalabnormalDate of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

_____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? yesnoDose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____

_____

_____

_____