breathe & balance

Acupuncture and Integrative Medicine

Acupuncture &Traditional Chinese Medicine Intake Form

Name:_____ Date of Birth: _____

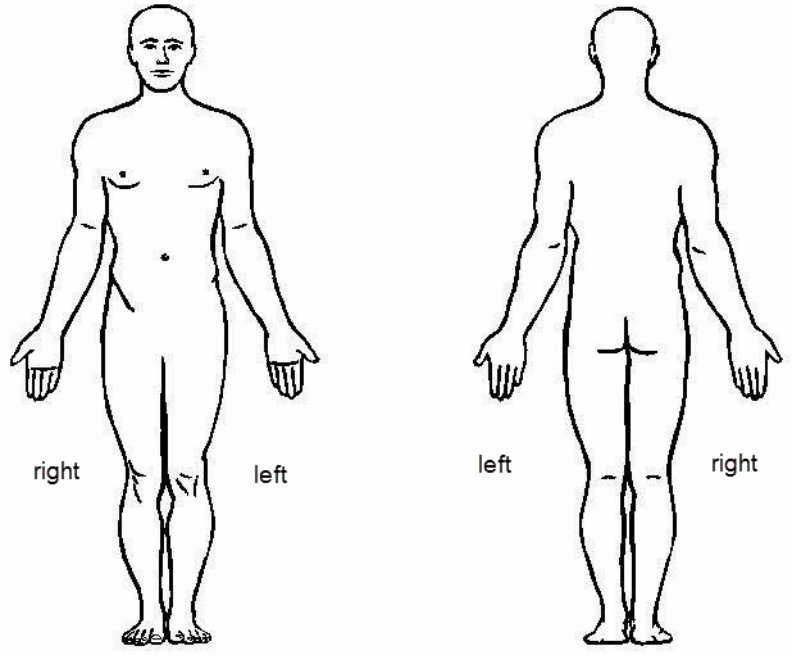
Have you had acupuncture before? Yes No If "yes", for what condition? _____

What are your main concerns: 1. _____2. _____3. _____

What current treatments are you receiving for your concerns?

Physical therapy/ chiropractic / massage therapy / other _____ / none

Location of pain: (on the diagram below please circle ○ areas of pain or mark **X** for numbness/tingling)



Circle quality of pain:

throbbing	shooting
stabbing	sharp
hot burning	aching
heavy	cramping

How long have you had this pain:

3 months or less	12 – 24 months
3 – 6 months	more than 24 months

How often does this pain occur?

continuously	1 or 2 times a day
several times a day	Several days a week
Less than 4 times a month	

Is this pain a result of: cancer treatment / following an operation / no obvious cause / _____

For the following sections, please check off all symptoms that you are experiencing now or within the past 6 months:

	nausea		gas		diarrhea
	vomiting		abdominal bloating		constipation
	belching		abdominal pain		blood in stools / black stools
	heartburn		decreased appetite		pus in stools
	bad breath		indigestion		hemorrhoids
	bleeding gums		low energy / fatigue		anal fissures
	ulcers		crave sweets		rectal pain
	excessive appetite		decreased ability to taste or smell		nose bleeds

	change in appetite		sweet taste in mouth		recurring sore throat
			often feel pensive / over thinking		difficulty swallowing
			edema		laryngitis / hoarse voice

	frequent colds		Asthma		dry skin
	sinus infection		bronchitis		itching
	cough		pneumonia		acne
	cough with blood		chronic obstructive pulmonary disease		rashes
	production of phlegm		often feel sad		hives
	hay fever or allergies		crave pungent foods		eczema
					psoriasis

	frequent urination		frequent urinary tract infections		impotence
	urgency to urinate		frequent vaginal infections		premature ejaculation
	pain on urination		pelvic inflammatory disease		testicular lumps
	urine / bowel incontinence		abnormal PAP smear		prostatitis
	weak urine stream		irregular periods		
	blood in urine		premenstrual syndrome		genital itching / pain
	kidney stones		painful menstrual periods		genital lesions / discharges
	low back pain		abnormal bleeding		decreased libido
	sore / weak knees		menopause symptoms		
	crave salty foods		breast lumps		ear ringing – low pitch
	often feel afraid		infertility		ear ringing – high pitch
	endometriosis		decreased hearing		fibrocystic breast
	fibroids/ovarian cysts		ear infections		

	dry eyes		Insomnia		migraine
	red eyes		excessive / vivid dreams		dizziness
	eye inflammation		grinding teeth		fainting
	blurred vision		depression		seizures
	poor night vision		anxiety / stress		localized weakness
	floaters (spots in visual field)		Irritability		numbness or tingling of limbs
	visual changes		treated for emotional / psychological problems		Tremors
	glasses / contact lenses		indecisiveness		poor coordination
	cataracts		often feel angry		paralysis
	crave sour foods				aversion to wind
					tendonitis
					gallstones

	high blood pressure		chest pain or pressure		blood clotting disorders
	low blood pressure		jaw, neck, shoulder or arm pain		phlebitis
	palpitations		nausea		poor memory
	irregular heart beat		swollen hands or feet		crave bitter foods
					excessive joy

	fevers		chills		headache
	frequent or strong thirst		cold hands / feet		neck stiffness
	tend to feel warmer than others		tend to feel colder than others		concussion
	night sweats		cold sweats		enlarged lymph glands

	sweat easily		prefer warm food and drink		
	prefer cold food and drink				

	Arthritis		menstrual cramps		auto immune disease(s):
	irritable bowel syndrome		immune compromised		

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

_____

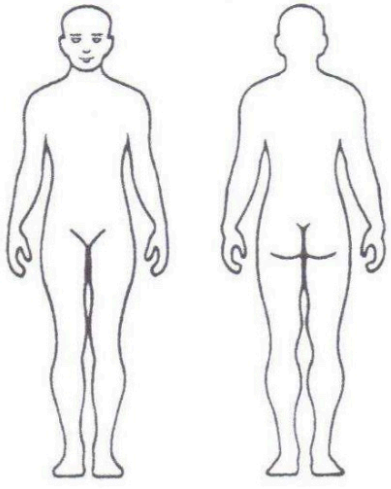
_____

_____

_____

_____

PLEASE CIRCLE AREAS OF CONCERN:



CURRENT COMPLAINT

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Any other things the Doctor should know or you care to share?

_____

_____

_____

_____

_____

_____

Family History – please complete for each family member by placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Diabetes							
Cancer/Tumor, Type:							
Seizures							
High Blood Pressure							
Drug use /(substance abuse)							
Alcohol abuse							
Heart Disease							
Stroke							
Depression / Mental Illness							
Age at Death							

Allergies – please list any known allergies (ex. food, hay fever, pollen, drugs, medication, etc.):

_____

_____

Sleep

What time do you typically go to sleep? _____ am / pm What time do you typically wake up?_____ am/pm

Is it difficult to stay asleep? Yes / No

Do you wake feeling rested? Yes / No

Stress Level (1=no stress, 10=high stress) _____

Major Hospitalizations – please list any hospitalizations (within 1 year) or surgeries:

Year Operation or Illness Name of Hospital City and State

_____

_____

_____

Other past or current infections (MRSA/ C-Diff, etc.)? _____

_____

Total Pregnancies: _____ Living _____ Ectopic _____ Miscarriages _____ Induced Abortions _____

Western Drugs – please list all current prescribed medications

Drug Name	Dosage	Frequency

Herbs & Supplements – please list all current herbs & supplements

Name	Brand	Strength	Frequency

Diet – please describe any restricted diet you follow now or have in the past: _____

_____

Appetite: Poor / Excessive	Coffee	Soft drinks	Recent weight: loss/ gain
Thirst for water ___ # of glasses per day	Salty foods	Sugar	Strongly like cold drinks / hot drinks

Please describe what you eat in a typical day:

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Evening Snack _____

How is your dental health? Good / fair / poor _____ When was your last visit to the dentist? _____

Do you exercise? Yes / No Gym, walking, running, cycling, yoga _____ / times per week _____

Do you have any spiritual practices? If so, please describe: _____

What are your goals for your health? _____

What are the top 3 priorities in your life? _____

To be completed by Acupuncturist:
T:
P:

LU/LI:	HT/SI:
SP/ST:	LV/GB:
PC/SJ:	KI/UB:

Assessment:
OM Dx:
OM Tx Principles:

Treatment Plan
Bilateral:

Right:

Left:

Midline:

Tx Methods and Reasoning: Acupuncture pts, Moxa, Cupping, Myofascial Release, Herbal Formula (dosage, administration), Supplements, Dietary & Lifestyle, lab/imaging, referrals

_____in # _____out

Follow up: _____ weekly for_____ weeks total # of visits _____