Acupuncture Center of Southwest MI (269) 353-4833

Patient Intake Form

Today's date ____________

Name ____________ Birth date ____________

Address ____________ Marital status ________ Ht. _____ Wt. _____ Age _____

____________ Occupation ____________ M ☐ F ☐

City, State, Zip ____________ Home phone ________ Work phone ________

E-mail ____________ Cell, pager, etc. ____________

Referred by ____________ Blood Type ________

Emergency contact's name & phone ____________

Main Problem: Other Concurrent Therapies

Past Medical History (include date):

Significant Illnesses:

_______Cancer _______Diabetes _______High Blood Pressure _______Heart Disease

_______Hepatitis _______Rheumatic Fever _______Thyroid Disease _______Seizures

_______ Other

Surgeries:
Significant Trauma (auto accidents, falls, etc.)
Patient Birth History: (prolonged labor, forceps delivery, etc.)
Allergies: (drugs, chemicals, foods.)
Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)
Occupational Stresses (Chemical, physical, psychological, etc.)
Exercise:
Average daily diet: Morning Afternoon Evening

Habits: ___Cigarettes ___Coffee ___Tea ___Cola ___Alcohol ___Drugs ___Sugar ___Salt Other ____________

Family Medical History ____Diabetes _____Cancer ____High Blood Pressure _____Heart Disease _____Stroke _____Seizures _____Asthma _____Allergies _____Alcoholism _____Other

Notes: ____________

GENERAL

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Poor Sleep
- ☐ Heavy Sleep
- ☐ Insomnia
- ☐ Fatigue
- ☐ Tremors
- ☐ Vertigo
- ☐ Cold hands
- ☐ Cold feet
- ☐ Cold Back
- ☐ Cold Abdomen
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Change in Appetite
- ☐ Localized weakness
- ☐ Poor Coordination
- ☐ Cravings
- ☐ Sudden energy drop at _______(time)
- ☐ Peculiar tastes/smells ____________
- ☐ Strong thirst (cold/hot drinks) ____________
- ☐ Bleed or bruise easily (where) ____________

SKIN AND HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Ulcerations
- ☐ Hives
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Change in hair/skin texture
- ☐ Purpura
- ☐ Other hair or skin problem

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Eyestrain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night Blindness
- ☐ Color blindness
- ☐ Spots in eyes
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Sinus Problems
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Mucus
- ☐ Dry throat
- ☐ Dry mouth
- ☐ Copious Saliva
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Facial Pain
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Recurrent sore throat ____/mo.
- ☐ Gum problems
- ☐ Headaches (where and when) ____________
- ☐ Other head or neck problems ____________

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Chest Pain
- ☐ Cold Hands/Feet
- ☐ Swelling in Hands/Feet
- ☐ Dizziness
- ☐ Fainting
- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Difficulty Breathing
- ☐ Other

RESPIRATORY

- ☐ Cough
- ☐ Coughing Blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tight Chest
- ☐ Difficulty in breathing in lying down
- ☐ Production of phlegm ________what color ____________
- ☐ Other lung problems

GASTROINTESTINAL

Bowel Movement:

__________Frequency

__________Color

__________Odor

__________Texture/form

- ☐ Vomiting
- ☐ Belching
- ☐ Bad Breath
- ☐ Nausea
- ☐ Diarrhea
- ☐ Rectal Pain
- ☐ Constipation
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Hemorrhoids
- ☐ Sensitive Abdomen
- ☐ Pain or Cramps
- ☐ Laxative Use: ____________/week; type: ____________________
- ☐ Gas

GENITO-URINARY

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Blood in urine
- ☐ Kidney Stones
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Venereal Disease
- ☐ Impotency
- ☐ Wake up to urinate How often ________/night; time: ________
- ☐ Other

PREGNANCY AND GYNECOLOGY

- ☐ Number of Pregnancies
- ☐ Number of Births
- ☐ Premature Births
- ______________Last Menses
- ☐ Age at first menses
- ☐ Period (days)
- ☐ Irregular Periods
- ______________Duration
- ☐ Flow (describe)
- ☐ Clots
- ☐ Miscarriages
- ______________Last Pap
- ☐ Vaginal Discharge
- ☐ Vaginal Sores
- ☐ Breast Lumps
- ______________Menopause
- ☐ Birth Control ______________type and duration ______________
- ☐ Changes in body/psyche prior to menstruation

MUSCULORSKELETAL

- ☐ Neck Pain
- ☐ Muscle Pain
- ☐ Back Pain (where) ______________
- ☐ Joint Pain ______________
- ☐ Other joint or bone problems?

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Easily Stressed
- ☐ Bad Temper
- ☐ Treated for emotional problems
- ☐ Considered/attempted suicide
- ☐ Other neurological or psychological problems?

CLASSICAL

Preference	Most Liked	Least Liked
Season		
Taste		
Climate		
Time of Day		
Temperature		

Color ______________

Tone ______________

Odor ______________

Yin/Yang ______________

Firm/Weak ______________

Hot/Cold ______________

Surface/Interior ______________

COMMENTS