Points of Health Acupuncture and Herbs

4205 Hillsboro Pike, Suite 306 N. Eden Goldring, L.Ac. 615-497-8839

PATIENT INTAKE FORM

Full name	Sex ❑ F ❑ M	Date
Date of birth Age	Occupation	
E-mail address	Home phone	Work phone
Address: Street	City	State Zip
In emergency notify	Marital status ❑ S ❑ M ❑ D ❑ W	# of children
Family physician	Chiropractor	
Have you been treated by acupuncture before? ❑ Yes ❑ No		
How did you find out about this clinic? ❑ *Friend/Relative* ______________________________ ❑ *Periodicals* ❑ *Location/Walk by* ❑ *Website* ❑ *Referred by* ____________________________ ❑ *Yellow pages* ❑ *Other (please specify):* ____		

Main Problem(s): You would like us to help you with ____

When did the problem begin? What are the precipitating factors?

Have you been given a diagnosis for this problem? If so, what?

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

What kind of treatment(s) have you tried?

What makes this problem worse? What make this problem better?

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

Medical History: (please include the month/year when the diagnosis was established)

Please check all conditions that apply:

Condition	Medication		Condition	Medication	
______Fibromyalgia	Yes	No	______Hepatitis	Yes	No
______Thyroid Disease	Yes	No	______Seizures	Yes	No
______HIV/AIDS positive	Yes	No	______Venereal Disease	Yes	No
______Digestive disorders	Yes	No	______Tuberculosis	Yes	No
______Breathing problems	Yes	No	______Heart Disease or Stroke	Yes	No
______ High Blood Pressure	Yes	No	______High Triglycerides	Yes	No
______Cancer	Yes	No	______Lung/Pulmonary Disease	Yes	No
______Kidney Disease	Yes	No	______Osteoporosis	Yes	No
______Ulcer	Yes	No	______Diabetes Mellitus	Yes	No
______Arthritis	Yes	No	______Anemia	Yes	No
______Neuromuscular Disease	Yes	No	______Gallbladder Disease	Yes	No
______Psychological Challenges	Yes	No			

Other (please specify):

Surgeries: Hospitalization: Significant trauma:

Allergies (drugs, chemicals, foods, animals):

Family Medical History: (please specify family member)

______Cancer	______Diabetes	______Hepatitis	______Autoimmune disease:
______Hypertension	______Heart disease	______Stroke	______Asthma
______Alcoholism	______Miscarriage	______Other (please specify)	

Medication:

Please list any medications you have taken within the last two (2) months. Include vitamins, OTC drugs, herbs, etc. and dosages).

Occupation:

Do you usually work ❑ indoors ❑ outdoors?

Occupational stressors (chemical, physical, psychological, etc.):

Personal:

Height: _________ Weight (present): _________ Weight (1 year ago): _________

Weight (maximum): _________ at year _________

Habits:

Do you smoke? ______ What? __________ How much per day? __________ Since when? _________

Please describe any use of drugs for non-medical purposes:

Do you exercise regularly? ❑ Yes ❑ No

Please describe exercise program: ____

How many hours do you sleep in general? ______ When do you usually go to bed? __________

Nutrition:

Do you drink caffeinated beverages? ❑ Yes ❑ No If so, how many per day? ______

Do you drink alcoholic beverages? ❑ Yes ❑ No If so, how many per week? ______

How much water do you drink per day? __________

Are you a vegetarian? ❑ Yes ❑ Yes, but not strict ❑ No

Do you eat a lot of spicy food? ❑ Yes ❑ No

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

Morning

Afternoon

Evening

Snacks

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Head
- ❑ Headaches
- ❑ Migraines
- ❑ Dizziness
- ❑ Memory Loss
- ❑ Concussions
- ❑ Other ______________

Eyes
- ❑ Blurred vision
- ❑ Pain
- ❑ Dryness
- ❑ Redness
- ❑ Glasses/lenses
- ❑ Eyestrain
- ❑ Color blindness
- ❑ Night blindness
- ❑ Cataracts
- ❑ Spots in front of eyes
- ❑ Other ______________

Ears
- ❑ Poor hearing
- ❑ Ringing
- ❑ Frequent ear infections
- ❑ Other _______________

Nose
- ❑ Frequent colds
- ❑ Sinus trouble
- ❑ Allergies
- ❑ Nosebleeds
- ❑ Drainage
- ❑ Other _____________

Mouth
- ❑ Gum problems
- ❑ Teeth problems
- ❑ Tongue/lip sores
- ❑ Jaw clicking/pain
- ❑ Unusual tastes

Throat
- ❑ Sore throat
- ❑ Difficulty swallowing
- ❑ Enlarged thyroid
- ❑ Other ____________

Respiration
- ❑ Asthma
- ❑ Bronchitis
- ❑ Chest pain
- ❑ Cough
- ❑ Coughing blood
- ❑ Difficulty breathing
- ❑ Phlegm
- ❑ Pneumonia
- ❑ Wheezing
- ❑ History of smoking
- ❑ Other ______________

Heart and Thorax
- ❑ Palpitations
- ❑ Rapid heart beat
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Tightness in chest
- ❑ Arteriosclerosis
- ❑ Prior heart attack

Circulation
- ❑ Bruise easily
- ❑ Cold hands and feet
- ❑ Fainting
- ❑ Phlebitis
- ❑ Varicose veins
- ❑ Anemia
- ❑ Other ______________

Skin
- ❑ Rashes
- ❑ Change in hair/skin texture
- ❑ Dryness
- ❑ Dandruff
- ❑ Eczema
- ❑ Hair loss
- ❑ Hives
- ❑ Itching
- ❑ Night sweats
- ❑ Pimples
- ❑ Purpura
- ❑ Recent moles
- ❑ Excessive sweating
- ❑ Coughing blood
- ❑ Other ______________

Gastrointestinal
- ❑ Poor appetite
- ❑ Bad breath
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Belching or heartburn
- ❑ Gas
- ❑ Abdominal pain/cramps
- ❑ Parasites
- ❑ Nausea
- ❑ Constipation
- ❑ Chronic laxative use
- ❑ Loose stools or diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Hemorrhoids
- ❑ Rectal pain
- ❑ Stomach pain
- ❑ Colitis or IBS
- ❑ Gallbladder trouble
- ❑ Other _________________

Urogenital
- ❑ Frequent urination
- ❑ Difficulty urinating
- ❑ Burning urination
- ❑ Frequent UTIs
- ❑ Waking to urinate
- ❑ Retention of urine/scanty urine
- ❑ Dribbling of urine
- ❑ Bedwetting
- ❑ Pause of flow - urination
- ❑ Itching of genitals
- ❑ Other ________________

Sleep
- ❑ Insomnia
- ❑ Drowsiness
- ❑ Night sweats
- ❑ Sleepwalking
- ❑ Excessive dreaming
- ❑ Not enough
- ❑ Other ________________

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Neuromuscular/skeletal
- ❑ Stiff neck
- ❑ Low back soreness/weakness
- ❑ Shoulder trouble
- ❑ Spinal curvature
- ❑ Pain between shoulders
- ❑ Knee trouble
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Hip pain
- ❑ Arthritis
- ❑ Hand/wrist pain
- ❑ Knee pain
- ❑ Sprain
- ❑ Hernia
- ❑ Sciatica
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Other _______________

Men's issues
- ❑ Prostate problems
- ❑ Discharge
- ❑ Impotence
- ❑ Frequent seminal emissions
- ❑ Fertility problems
- ❑ Ejaculatory problems
- ❑ Painful/swollen testicles
- ❑ Other ________________

Women's issues
- ❑ Painful menstrual periods
- ❑ Cramps or backache
- ❑ Fertility problems
- ❑ Ovarian cysts
- ❑ Excessive flow
- ❑ Endometriosis
- ❑ Light flow
- ❑ Clotting
- ❑ Irregular cycle
- ❑ Hot flashes
- ❑ Vaginal discharge
- ❑ Fibrocystic breasts
- ❑ Breast tenderness
- ❑ PMS
- ❑ Abnormal bleeding
- ❑ Low sex drive
- ❑ Other ________________

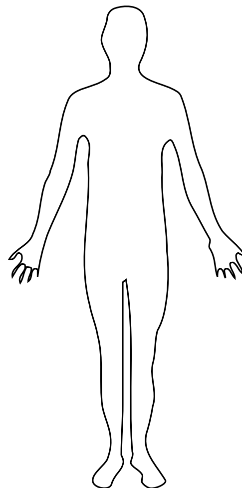
Number of pregnancies ______
Number of births ______
Number of miscarriages ______
Number of abortions ______
Premature births ______
Cesarean sections ______
Age of first menses ______
Duration of periods ______
Cycle length ___________
Do you practice birth control?
- ❑ Yes; type: ____________
- ❑ No

Energy level
- ❑ Low energy
- ❑ Excessive energy
- ❑ Hard to wake up
- ❑ Energy drop in afternoon
- ❑ Sudden energy drops

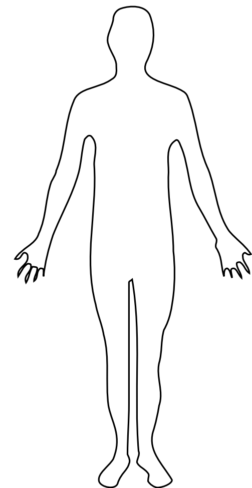
Emotional
- ❑ Depression
- ❑ Mania/bipolar
- ❑ Anxiety
- ❑ Bad temper
- ❑ Mood swings
- ❑ Stressed
- ❑ Other

Please indicate painful or distressed areas →

Front



Back



Signature: __________________

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