Acupuncture For Life
2032 N. Broad St., Suite 3
Lansdale, PA 19446
267-575-0592

Patient Intake Form

Name (last, first) _____ Date _____
Address _____
City / State / Zip _____
Birth Date _____
Home phone _____ Work Phone _____
Cell Phone _____
Email _____Occupation _____
Emergency contact _____(name & phone)
Referred by _____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed
___ Caregiver for dependent ___ Children _____

Have you ever had acupuncture? _____ If yes, when/where? _____

For what condition? _____

Are you currently under the care of a physician? _____If so, who, and for what condition(s)?_____
_____

Main reason(s) for seeking acupuncture?
_____
_____

Are you working with an attorney for your condition? Yes or No

How long have you experienced symptoms? _____

Your condition is improved by: _____

Your condition is aggravated by:_____
_____

List all current medications, prescribed or over the counter
_____
_____
_____

List all current vitamins, herbs and other supplements
_____
_____
_____

Significant illnesses (please check all that apply)

___ Cancer
___ Diabetes
___ Hepatitis
___ Heart Disease
___ Stroke
___ Seizures
___ HIV / AIDS
___ Pneumonia
___ Tuberculosis
___ Multiple sclerosis
___ Thyroid
___ Asthma
___ Stomach Ulcers
___ Obesity
___ Depression
___ Shingles
___ Chronic Fatigue
___ Rheumatic Fever
___ High Blood Pressure
___ STD's
___ Other _____

Please list any surgeries you've had including dates _____
_____
_____
_____

Please list any Allergies _____
_____
_____

Please list any major emotional or physical traumas you've experienced
_____
_____
_____

Lifestyle (please check all that apply, and note frequency of use)

___ Tobacco
___ Alcohol
___ Recreational drugs
___ Caffeinated beverages

Do you exercise? _____ Please list types of activity and frequency:
_____
_____
_____

Dietary preferences

___ Vegetarian
___ Raw foods diet
___ Low fat diet
___ High protein/low carb
___ Dairy /milk /cheese
___ Eggs
___ Chicken
___ Fish / seafood
___ Red meat
___ Artificial sweeteners
___ Fast food/ burgers/ fries
___ Spicy / hot
___ Sweet
___ Sour
___ Salty
___ Cold drinks
___ Hot drinks
___ Ice chewing
___ Extreme thirst
___ Thirst with no desire to drink

General symptoms

___ Fatigue
___ Sweat without exertion
___ Night sweats
___ Fever / chills
___ Dizziness / vertigo
___ Bleed / bruise easily
___ Low immunity
___ Other _____

Digestion

___ Extreme appetite
___ No appetite
___ Cravings
___ Dieting
___ Tired after eating
___ Bloating
___ Gas
___ Acid regurgitation
___ Heartburn/Ulcers
___ GERD
___ Nausea
___ Vomiting
___ Bulimia
___ Anorexia
___ Irritability or low energy between meals
___ Other _____

How many meals per day? _____ How many snacks per day? _____

Intestinal

___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use
___ Bloody stool
___ Mucous in stool
___ Anal fissures
___ Rectal prolapse
___ Intestinal pain/cramping
___ Incomplete evacuation
___ IBS
___ Colitis
___ Crohn's Disease
___ Gout
___ Celiac Disease
___ Gallstones
___ Other _____

Sleep

___ Falls asleep easily
___ Lie in bed with eyes open
___ Wake as specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams
___ Wake up not feeling rested
___ Nightmares or Frightening dreams
___ Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat

___ Dry eyes
___ Spots / flowery vision
___ Blurred vision
___ Poor vision
___ Eye strain
___ Night blindness
___ Cataracts
___ TMJ
___ Sores on tongue or mouth
___ Dry mouth___ Excess saliva
___ Sinus problems
___ Swollen glands
___ Earaches
___ Difficulty swallowing
___ Headaches
___ Tinnitus / ringing
___ Nosebleed
___ Bleeding gums
___ Post-nasal drip
___ Sore throat
___ Deafness

Cardiovascular / respiratory

___ Heart palpitations
___ Chest pain
___ Difficulty breathing
___ High cholesterol
___ Varicose veins
___ Blood clots
___ Swollen ankles
___ Heart valve abnormality
___ Shortness of breath
___ Cold hands / feet
___ Dry cough
___ Wheezing
___ Chest tightness
___ Difficult inhalation
___ Difficult exhalation
___ Productive cough (color of phlegm?)
___ Other _____

Skin / hair

___ Dry skin
___ Rashes / hives
___ Eczema
___ Psoriasis
___ Pimples / acne
___ Fungal infections
___ Brittle nails
___ Ridged nails
___ Hair loss
___ Dandruff
___ Other _____

Musculoskeletal

___ Spinal pain
___ Joint pain
___ Tendonitis
___ Swelling
___ Arthritis
___ Limited range of motion
___ Disc degeneration
___ Osteoporosis
___ Numbness
___ Carpal tunnel
___ Fibromyalgia
___ Other _____

Neuropsychological

___ Anxiety
___ Irritability
___ Insomnia
___ Depression
___ Easily stressed
___ Poor memory
___ Seasonal mood disorder
___ Tics
___ Tremors
___ Death of someone close
___ Job stress
___ Recent divorce
___ Currently in therapy
___ Financial setback
___ Other _____

Emotional stress scale

1 2 3 4 5 6 7 8 9 10
no stress moderate stress extremely stressed

Rate your stress level regarding:

Work _____
Health _____
Love _____
Money _____
Family _____
The future _____

Genito-urinary

___ Frequent urination
___ Loss of urine when laughing or sneezing
___ Incomplete urination / retention
___ Dribbling
___ Burning urination
___ Blood in urine
___ Wake frequently to urinate
___ Kidney stones
___ Bedwetting
___ Bladder prolapse
___ Decreased libido / sexual desire
___ Other _____

Men only

___ Enlarged prostate/prostatitis
___ Prostate cancer
___ Testicular cancer
___ Testicular pain or swelling
___ Erectile dysfunction
___ Impotency
___ STD's _____

Women only

Age menses began _____ Age menses ended (if applicable)_____
Date of last ob/gyn exam _____
Hysterectomy? ___ partial ___ full

___ Hormone replacement therapy
___ Live births
___ Miscarriage
___ Abortions
___ Infertility
___ Birth control pills
___ Breast cancer
___ Ovarian cysts
___ Fibroids
___ Endometriosis
___ Candida / yeast
___ Vaginal discharge
___ Vaginal odor
___ Vaginal sores
___ Herpes
___ Human Papilloma Virus positive
___ Uterine prolapse
___ STD history (chlamydia, PID, etc)
___ Fibrocystic breast

Period lasts _____ days Usual number of days in cycle _____
Headaches ___ before menstrual cycle ___ during cycle ___ after cycle

___ Pain at ovulation
___ Cramps / low back pain
___ Acne associated with period
___ Constipation associated with period
___ Diarrhea associated with period
___ Depression or irritability with period
___ Bleeding outside of normal menstrual cycle
___ No period / skipped cycles
___ Irregular cycle

Menstrual flow is:

___ Clotting
___ Brownish
___ Watery, thin and bright red
___ Normal red
___ Flooding and trickling
___ Stop and start flow

If you have been evaluated for infertility, what was your diagnosis?

_____
_____