Acupuncture & TCM Intake Form

Date: _____

Name: _____

What is your reason for this visit?

_____

What (if any) medical diagnosis have you received?:

_____

What (if any) treatments have/are you receiving?:

_____

Please list all medications, herbs and supplements you are taking and their dosage:

_____

_____

_____

Are you allergic to any medicines or substances? If so, what?

_____

Hospitalizations: (*list as best you can with the date and illness or procedure*)

_____

_____

_____

EMOTIONS AND SLEEP

How would you characterize your emotional life?

_____

Please circle those that you currently experience, and underline those experienced in the past:

Anxiety	Poor memory	Panic attacks	Difficulty concentrating
Depression	Fearfulness	Irritability/anger	Racing thoughts
Confusion	Frequent sighing	Chest tightness	Worry

Are you in a relationship? How do you feel about it?

_____

How do you feel about work?_____

How would you rate your stress level? (1 low -10 high) _____
How does your stress manifest itself?

_____

How do you cope with your stress?

_____

How do you relax?

_____

What time do you: Go to bed ____ am/pm Fall asleep ____ am/pm Get up____ am/pm
How many hours of sleep to get? _____ Do you feel refreshed? _____

I have difficulty with… (circle any that apply)

Falling Asleep	Staying Asleep	Dream-disturbed Sleep
Recurrent dreams	Nightmares	Waking to urinate, ____ # of times
Waking, with trouble falling back to sleep.		What time? _____

LIFESTYLE

What do you do for exercise?

_____

How many times per week?_____ Duration_____

Do you smoke? Yes No Are you exposed to smoking on a regular basis? Yes No

Do you actively participate in a spiritual discipline? Yes No

Do you experience allergic reactions to anything? Yes No

If yes, please explain.

_____

_____

GASTROINTESTINAL

Please circle those that you currently experience, and underline those experienced in the past:

Bitter taste	Metallic taste	Sticky taste
Loss of appetite	Gnawing hunger	Belching
Nausea	Vomiting	Heartburn
Indigestion	Vomiting of blood	Ulcers
Acid reflux	Food cravings: _____	

Frequency of bowel movements: _____ x per day/week

Constipation	Diarrhea	Irregular
Bloating	Cramping	Burning sensation
Loose stools	Hard stools	Painful to pass
Undigested food	Gas	Pellet-like stools
Mucous in stools	Blood in stools	Strong odor

FLUID METABOLISM AND ELECTROLYTES

How much liquid to you consume daily? _____. Are you thirsty? Yes No
What temperature of beverages do you prefer? Hot Cold Room temperature

Please circle those that you currently experience, and underline those experienced in the past:
Yellow sweating *(can be noticed as stains on armpits and neckline of clothing)*

Spontaneous sweating	Night sweating	Sweaty palms
Frequent urination	Incontinence	Kidney stones
Burning urination	Urinary tract infection	Cloudy urination
Blood in urine	Weak urine stream, or trouble starting	

EARS EYES NOSE THROAT AND HEAD

Do you experience headaches/migraines? Yes No How often? _____
Where are these headaches located?

Unilateral	Bilateral	Temples	Behind eye(s)
Occipital/neck	Top of head	Forehead	Whole head
Sinuses	Fixed spot	Moving	

What type of pain do they present with?

Boring/stabbing	Dull/achy	Throbbing	Wrapped up
Full	Stiffness/pulling	Bursting.	Empty

What makes them better? _____
What triggers or aggravates them? _____

How many times per year do you catch colds/flus? _____
What kind? *(e.g. common cold, influenza, intestinal flu, or other)* _____
How would you characterize your body temperature? Hot Cold Neither
Does this change at different times of the day? Yes No

Please circle those that you currently experience, and underline those experienced in the past:

Chills	Fever	Alternating chills & fever
Chronic cough	Nose bleeds	Bleeding gums
Canker sores	Cold sores	Dry mouth
Sore throat	Dry throat	Lump in throat
Excessive mucous	Bad breath	Dry eyes
Red/painful eyes	See spots/floaters	Ear pain
Blurred vision	Dizziness/vertigo	Ear ringing
Cataracts	Glaucoma	Facial palsy/tic

MALE REPRODUCTIVE

Are you sexually active? Yes No Date of last prostate exam: _____

Please circle those that you currently experience, and underline those experienced in the past:

Vasectomy	Prostate problems	Male infertility
Painful erection	Difficult/premature ejaculation	Erectile difficulty
Penile discharge	Swelling, lumps, pain in testes	

FEMALE REPRODUCTIVE

Please circle those that you currently experience, and underline those experienced in the past:

Lumps in breast	Nipple discharge	Breast pain
Pelvic pain	Vaginal discharge	Vaginal itching/burning
Unpleasant odor	Genital eruptions	Painful sex
Lack of sexual desire	Excessive sexual desire	Menstruation absent
Spotting between periods	Clotting in menstruation	Heavy menstruation

Are you sexually active? Yes No Do you use birth control? _____
Have you ever used birth control pills? Yes No How long? _____

Age of first menstruation: _____ Periods occur every _____days, and last _____ days
Are your periods regular? Yes No Date of last period: _____

Please indicate any of the following that you experience, and underline those that you have experienced in the past. Mark 'B' for before, 'D' for during, and 'A' for after your period.

____ Mood changes	____ Irritability/anger	____ Anxiety
____ Insomnia	____ Crying	____ Forgetfulness
____ Clumsiness	____ Fatigue	____ Dizziness/faint
____ Abdominal bloating	____ Increased appetite	____ Sweet cravings
____ Weight gain	____ Breast tenderness	____ Back pain
____ Cramping	Other (*please specify*)_____	

Have you had in the past, or do you currently experience problems with fertility? If yes, please explain:

_____

_____ # of pregnancies _____ # of births _____ # of miscarriages _____ # of abortions

Any complications of pregnancy? Yes No

If yes, please explain

_____

PAIN

What type of pain do you experience? Please mark '1' for mild, '2' for moderate and '3' for severe.

___ Wandering pain	___ Fixed pain	___ Superficial pain
___ Deep pain	___ Stabbing pain	___ Pricking pain
___ Burning pain	___ Shooting pain	___ Sharp pain
___ Dull pain	___ Aching	___ Gripping pain
___ Numbness	___ Tingling	___ Pins & needles

What makes the pain better or worse? (*Mark those factors that make the pain better with a'B', and those that make the condition worse with a 'W')*

___ Application of cold	___ Application of heat	___ Application of pressure
___ When resting	___ When active	___ When tired
___ When under stress	___ Upon waking	___ In the evening/night

Other, please explain _____

Explain where your pain is anatomically

_____
_____
_____
_____
_____