

# Patient Intake Form

Today's Date \_\_\_\_\_

Name	Birthdate	Age	Ht.	Wt.
Address	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
City, State, Zip				
Home Phone	Mobile	Work		
E-Mail Address				
Occupation				
Emergency Contact: Name & Phone				

Reason for visit today	Have ever had acupuncture? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you had this condition?		
Is it getting worse?	Does it bother your: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Other (what?)	
What seemed to be the initial cause?		
What seems to make it better?		
What seems to make it worse?		
Are you under the care of a physician now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what?
Who is your physician?		Physician's Phone
Other concurrent therapies		

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## Health Insurance

Insurance Co. Name	Policy#
Address	Phone
City, State, Zip	

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## Medicare

Insurance Co. Name	Policy#
Address	Phone
City, State, Zip	

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## Family Medical History

<input type="checkbox"/> Allergies	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
_____	<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
_____	<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> High Blood Pressure	

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## Your Past Medical History

<input type="checkbox"/> AIDs/HIV	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Major Trauma	<input type="checkbox"/> Other (Specify & list)
<input type="checkbox"/> Allergies	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pneumonia	(Car, Fall, etc.-list)	
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gout	<input type="checkbox"/> Polio		
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scarlet Fever		
<input type="checkbox"/> Birth Trauma (your own)	<input type="checkbox"/> Herpes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Typhoid Fever	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Surgery (list)	<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple Sclerosis		<input type="checkbox"/> Venereal Disease	
	<input type="checkbox"/> Mumps			

## Your Lifestyle

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Drugs	<b>Regular Exercise</b>	
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Stress	Type	Frequency
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Occupational Hazards	Type	Frequency

## General Symptoms

<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Bodily heaviness	<input type="checkbox"/> Chills
<input type="checkbox"/> Heavy appetite	<input type="checkbox"/> Heavy sleep	<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Strongly like cold drinks	<input type="checkbox"/> Dream-disturbed sleep	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Strongly like hot drinks	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Muscle cramps
<input type="checkbox"/> Recent weight loss/gain	<input type="checkbox"/> Lack of strength	<input type="checkbox"/> Fever	<input type="checkbox"/> Vertigo or dizziness
<input type="checkbox"/> Bleed or bruise easily	<input type="checkbox"/> Peculiar taste (describe)		

## Head, Eyes, Ears, Nose, Throat

<input type="checkbox"/> Glasses	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Sores on lips or tongue	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Migraines
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Lumps in Throat	<input type="checkbox"/> Concussions
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Excessive saliva	<input type="checkbox"/> Enlarged thyroid	Other head or neck problems
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeds	
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Excessive phlegm	<input type="checkbox"/> Ringing in ears	
<input type="checkbox"/> Spots in eyes	<input type="checkbox"/> TMJ	<input type="checkbox"/> Color of phlegm	<input type="checkbox"/> Poor hearing	
<input type="checkbox"/> Poor vision	<input type="checkbox"/> Facial pain		<input type="checkbox"/> Earaches	
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Gum problems	<input type="checkbox"/> Recurrent sore throat	<input type="checkbox"/> Headaches	

## Respiratory

<input type="checkbox"/> Difficulty breathing when lying down	<input type="checkbox"/> Asthma/wheezing		Thick or thin?	<input type="checkbox"/> Coughing blood
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Cough		Color of phlegm	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Tight chest	wet or dry?			

## Cardiovascular

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Fainting	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Irregular heartbeat

## Gastrointestinal

<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Itchy anus	Bowel movements:
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Burning anus	Frequency
<input type="checkbox"/> Acid regurgitation	<input type="checkbox"/> Laxative use	<input type="checkbox"/> Rectal pain	Color
<input type="checkbox"/> Gas	<input type="checkbox"/> Black stools	<input type="checkbox"/> Hemorrhoid	Texture/form
<input type="checkbox"/> Hiccup	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Anal fissures	Odor
<input type="checkbox"/> Bloating	<input type="checkbox"/> Mucous in stools		
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Intestinal pain or cramping		

## Musculoskeletal

<input type="checkbox"/> Neck/shoulder pain	<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Limited range of motion	Other (describe)
<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Rib pain	<input type="checkbox"/> Limited use	

## Skin and Hair

<input type="checkbox"/> Rashes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Change in hair/skin texture	Other hair or skin problems
<input type="checkbox"/> Hives	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Itching	<input type="checkbox"/> Fungal infections	
<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Acne	<input type="checkbox"/> Hair loss		

## Neuropsychological

<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Irritability	<input type="checkbox"/> Considered/attempted suicide	Other (specify)
<input type="checkbox"/> Numbness	<input type="checkbox"/> Depression	<input type="checkbox"/> Easily stressed	<input type="checkbox"/> Seeing a therapist	
<input type="checkbox"/> Tics	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Abuse survivor		

## Genito-urinary

<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Impotence
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Premature ejaculation
<input type="checkbox"/> Urgent urination	<input type="checkbox"/> Incomplete urination	<input type="checkbox"/> Wake to urinate	<input type="checkbox"/> Kidney stone	<input type="checkbox"/> Nocturnal emission

## Gynecology

<input type="checkbox"/> Age menses began	<input type="checkbox"/> Duration of flow	<input type="checkbox"/> Vaginal discharge (color)	# Pregnancies	Age at Menopause
Length of cycle (day 1 to day 1)	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Vaginal sores	# Live Births	Date of last PAP
	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Vaginal odor		
	<input type="checkbox"/> PMS	<input type="checkbox"/> Clots	Premature births	Date last period began
		<input type="checkbox"/> Breast lumps		

## Other

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