ZoeAcupuncture
...Live Well

Patient Intake Form

PATIENT INFORMATION Date: _____

This is a confidential questionnaire designed to help determine the best treatment plan for you. Please answer all questions as completely as possible.

Name: _____
First Middle Last

Address: _____
Street City State Zip

Cell Phone: _____ Home Phone: _____

Email: _____

Age: _____ Date of Birth: _____/_____/_____ Marital Status: S M D W
MM DD YY

Sex: M F

Height: _____ Weight: _____

Place of Birth: _____ Social Security #: _____

Emergency Contact: _____
Name Relation Phone #

Occupation: _____Employer:_____

Have you received acupuncture therapy before? Y N

Present Illness:

What are the chief complaints in order of importance that brought you into this office?

How long have you been living with each condition?

If you are experiencing pain, on a scale of 1-10 how severe is it? _____

On a scale of 1-10, how much do your health problems affect your daily activities of living?
(1 is no problem, 10 is major problem) _____

What other therapies have you received for this condition?

What type of care do you desire?

_____ Temporary relief of symptoms /pain control.
_____ Balanced health-care, elimination of root cause of problem if possible
_____ Maintenance care/ balance to stay in good health.

How much change, if any, are you willing to make in your life to improve these ailments?

Some _____ Moderate _____ All that are required _____

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Medical History

List all major accidents, surgeries, or hospitalizations including date or age.

List any medications you are currently taking. Be sure to include things such as: laxatives, pain relievers, appetite suppressants, antacids, and any other prescription medications.

Please list all vitamins, minerals, herbs, homeopathic remedies and nutritional supplements you are currently taking:

Do you have any known allergies to food, drugs or environmental factors?

When and where were you last seen by a western medical physician?

Name of physician: _____
Contact Phone: _____
Date: _____
Reason for visit: _____
Diagnosis: _____
Is this treatment ongoing? _____

In your immediate family, has anyone else had the following diseases? If yes, please indicate the relationship to you.

Cancer_____ Tuberculosis_____Diabetes _____
Stroke _____ Hypertension_____ Asthma _____
Hepatitis _____ Alcoholism _____ Epilepsy_____
Heart disease _____Mental Disease _____

Medical History Questionnaire

Check any current conditions or those you have had in the past.
Write PAST next to those conditions which you have had ONLY in the past and are no longer present

Head and Neck:
__ Fainting
__ Dizzy spells
__ Light headed
__ Headaches
__ Cluster headache
__ Migraines
__ Neck tension

Ears:
__ Ringing in ears
__ Ear popping
__ Decreased hearing
__ Frequent Infections

Skin:
__ Rashes
__ Bruise easily
__ Hives
__ Eczema
__ Dry skin/ itching
__ Psoriasis
__ Easy sweating
__ Night sweats
__ Dry scalp

Neurological:
__ Nerve pain
__ Seizures
__ Hand tremors
__ Numbness of limbs
__ Paralysis
__ Epilepsy

Emotions:
__ Depression
__ Mania
__ Irritability

Eyes:
__ Blurred vision
__ Dry eyes
__ Poor night vision
__ Spots/ Floaters
__ Excessive tearing
__ Glaucoma/ cataracts
__ Glasses/ contacts

Respiratory:
__ Asthma/ wheezing
__ Chronic cough
__ Frequent colds
__ Emphysema
__ Bronchitis/ pneumonia
__ Shortness of breath
__ Coughing up blood

Gastrointestinal:
__ Bloating/ Indigestion
__ Acid reflux
__ Nausea/ Vomiting
__ IBS
__ Crohn's Disease
__ Colitis
__ Celiac Disease
__ Ulcers (duodenal/ gastric)
__ Loose stools (__/day)
__ Constipation (__/week)
__ Dry, hard stool
__ Changes in bowel habits
__ Excessive hunger
__ Lack of appetite
__ Excessive thirst
__ Halitosis
__ Hemorrhoids
__ Blood in stool
__ Gall bladder disease

Nose, Throat & Mouth:
__ Sinus infections
__ Allergies
__ Loss of smell
__ Sore throat
__ Cold sores
__ Lymph swelling
__ Nose bleeds
__ TMJ
__ Bitter taste in mouth
__ Loose teeth
__ Difficulty swallowing
__ Bleeding gums
__ Teeth grinding

Cardiovascular:
__ Palpitations
__ Heart murmur
__ Chest tightness
__ High blood pressure
__ Poor circulation
__ Cold hands or feet
__ Ankle swelling
__ Pacemaker
__ Stroke
__ Angina
__ Heart disease

Muscles and Joints:
__ Muscle weakness
__ Scoliosis
__ Fibromyalgia
__ Difficulty walking
__ Low back pain
__ Backache
__ Muscle soreness
__ Bursitis/ tendonitis
__ Rheumatoid arthritis

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__ Unresolved grief
__ Indecision
__ Panic attacks/ anxiety
__ Obsessive/ compulsive
__ Excessive worrying
__ Loneliness

__ Food cravings
__ Recent weight changes
__ Trouble losing weight
__ Trouble gaining weight
__ Stomach Prolapse

__ Osteoarthritis
__ Shoulder tension
__ Gout
__ Lyme's disease

Urinary:
__ Frequent urination (__/ D)
__ Frequent UTI's
__ Weak urinary stream
__ Kidney stones
__ Dark urine
__ Edema

Viral/ Autoimmune/Endocrine
__ Epstein Barr
__ Rheumatic fever
__ Diabetes Mellitus
__ Thyroid Disorder Hyper/Hypo
__ Multiple Sclerosis
__ Shingles
__ Lupus erythematosis
__ Hypoglycemia

Miscellaneous:
__ Fatigue
__ Aversion to cold
__ Aversion to heat
__ Insomnia
__ Poor memory
__ Trouble focusing
__ ADD/ ADHD
__ Anemia
__ Eating disorders
__ Thinning hair
__ Varicose veins
__ Low libido
__ Nightmares
__ Hernia
__ Surgical implants

Infection History:
__ HIV/AIDS or risk (partner)
__ TB: self or household
__ Hepatitis or risk (partner)
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital warts
__ Herpes (oral) __ Genital

Gynecological:
__ PCOS
__ Endometriosis
__ Infertility
__ Uterine Fibroids
__ Cysts/ Polyps

FOR WOMEN ONLY

Are you pregnant?_____ # children_____ # miscarriage_____ # terminations_____
Age at first menarche _____ Age at menopause _____
What was the date of the start of your most recent menstrual period? _____
How long do your periods last? _____ Are your cycles regular? _____
How long is your cycle (from the start of one period to the start of the next)? _____
Color: Light Normal Dark
Do you have discharge between your periods? (white or yellow) _____
Do you experience cramps, pain, clotting or bloating during your period? _____
Do you experience night sweats or hot/cold flashes? _____

Pre-Menstrual Symptoms:
Do you experience any of the following prior to your menstrual period?

_____ Breast Tenderness
_____ Mood Changes
_____ Diarrhea
_____ Breast discharge

_____ Bloating
_____ Headache
_____ Low Back Pain
_____ Constipation

_____ Skin Problems
_____ Cramping
_____ Appetite Changes
Other _____

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Do any of the above symptoms become more severe following your cycle?

Date of last PAP _____ Date of last mammogram _____
Ever had an abnormal PAP_____ Diagnosis _____
Surgery or DNC? _____

FOR MEN ONLY

__ Sexual Difficulties	__ Prostate Problems	__Testicular Pain/Swelling
__ Penile Discharge	__ Prostatitis	__ Testicular cancer
__ Painful ejaculation	__ Prostate Cancer	__ Penile cancer
__ Premature ejaculation	__ Low sperm count	__ Impotence
__ Genital/ jock itch	Other_____	

Personal Lifestyle History

Do you eat three meals per day?	Yes	No	Do you eat breakfast?	Yes	No
How many hours of sleep each night? _____					
Do you wake feeling rested?	Yes	No			
Do you spend time outside?	Yes	No			
Do you have a supportive relationship?	Yes	No			
Any history of sexual or physical abuse?	Yes	No			
Do you take vacations?	Yes	No			
Do you exercise?	Yes	No	Which types _____		
Do you enjoy your job?	Yes	No			
Do you drink coffee?	Yes	No	Amount per day week _____		
Do you drink black tea?	Yes	No	Amount per day/week _____		
Do you drink sodas or energy drinks?	Yes	No	Amount per day/week _____		
Do you consume alcohol?	Yes	No	Amount per day/week _____		
Beer _____ Wine _____ Spirits _____					
Do you smoke?	Yes	No	Amount Per day _____		
Year started _____ Year stopped_____					

Do you have a history of recreational drug use (cocaine, marijuana, heroin, barbiturates, amphetamines, narcotics), past or present?

How often do you consume of the following?

White flour products:	NEVER	RARELY	SOMETIMES	FREQUENT
Fast foods:	NEVER	RARELY	SOMETIMES	FREQUENT
Refined sugar:	NEVER	RARELY	SOMETIMES	FREQUENT
Red meat or pork:	NEVER	RARELY	SOMETIMES	FREQUENT
Fresh vegetables:	NEVER	RARELY	SOMETIMES	FREQUENT
Fresh fruit:	NEVER	RARELY	SOMETIMES	FREQUENT
Green leafy vegetables:	NEVER	RARELY	SOMETIMES	FREQUENT
Sweets/desserts/candy:	NEVER	RARELY	SOMETIMES	FREQUENT

PLEASE STOP HERE

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