Blue Lotus Acupuncture Center Intake

Back

Date _____/_____/_____ Practitioner/s_____(/)_____(for office use)

PLEASE PRINT

Name _____ Gender ___ Male ___ Female

Date of Birth _____/_____/_____ Email address _____

Address _____

City _____ State _____ Zip Code _____

Occupation _____ Contact phone _____

Cell phone _____ Referred by _____

In emergency, notify _____ Telephone _____

Relationship to patient _____

Do you have insurance that covers acupuncture? ___ Yes ___No

Have you contacted the company to verify this? (If so, please download/request Insurance form)

Chief Complaint(s) _____

Condition onset (approximate date) _____ Was it ___ sudden ___ gradual

Symptoms are relieved by _____ worsened by _____

Is condition ___ getting worse ___ constant ___ comes and goes?

Have you received a medical diagnosis? __Yes __ No If yes, what? _____

When were you last seen by a Medical Doctor?_____

Describe recent treatments you have had for the above or other conditions _____

Medical History (please check all that apply)

____ Alcoholism
____ Allergies
____ Arthritis
____ Asthma
____ Birth trauma
____ Cancer
____ Chronic fatigue
Fibromyalgia
____ Diabetes
____ Digestive Problems
____ Drug abuse
____ Heart disease
____ Hepatitis A/B/C
____ High blood pressure
____ HIV/AIDS
____ Kidney/bladder disease
____ Liver Disease
____ Lung/Breathing Problems
____ Lyme disease
___ Mental illness
___ Metal allergies
___ Nervous system disease (MS etc)
___ Polio
___ Seizures
___ Stroke
___ Thyroid problems
___ Tuberculosis
___ Others _____

List major injuries, surgeries or illnesses. Include dates and hospitalizations, if appropriate.

_____

_____

Blue Lotus Acupuncture Intake Form Patient _____

List current Medications (please include hormones) and for what conditions you are taking them

_____

_____

List all Vitamins, Supplements, and Herbs (include any Chinese herbal formulas) you are taking _____

_____

_____

Do you generally feel hot or cold?_____

Gastrointestinal

Do you have (Check ALL that apply) ___ Belching ___ Nausea ___ Vomiting ___ Vomiting blood ___ Ulcers ___ Bloating ___ Acid ___ Regurgitation ___ Heartburn ___ Indigestion ___ Severe stomach pain __ Bitter/Sour taste in mouth ___ Weight gain ___ Weight loss ___ Other (describe) _____

How often do you have bowel movements? _____ days/week (circle) Are they painful? ___ Yes ___ No

Do you have (Check ALL that apply) ___ Irregularity ___ Constipation ___ Diarrhea ___ Gas ___ Burning ___ Hemorrhoids ___ Use laxatives ___Undigested food in stool ___ Loose stool ___ Hard stool ___ Blood in stool ___ Itchiness ___ Other (describe)_____

Exercise & Energy

How is your energy? ___ low ___ normal ___ high. At what time is it highest? _____ lowest? _____
Do you fatigue easily? ___ Yes ___ No. Do you exercise? ___Yes ___ No
If yes, what type of exercise? _____ How many times/week? _____

Women

___ Low sex drive ___ Lack of sex drive. ___High sex drive At what age did you start menstruating? _____
Number of days between cycles ____ Days of flow _____ Color _____
Menses: ___ Irregular menstruation ___ Heavy flow ___ Light flow ___ No flow ___Clots ___ Vaginal itching/burning ___ Spotting between periods _____ Discomfort/pain
Any vaginal discharge? ___ Yes ___ No Amount _____ Color _____ Frequency _____
PMS symptoms _____
Peri-menopausal symptoms _____
Menopausal symptoms _____
Birth control _____ Have you been pregnant? ___Yes _____# of pregnancies
Any issues during pregnancy? ___Yes Explain _____
Are you trying to get pregnant? ___ Yes ___ No Infertility Issues _____

Men

Do you have (Check ALL that apply) ___ Prostatitis ___ Impotence ____ Penis blood/mucous discharge ____ Low sex drive ____ Lack of sex drive ____ Very high sex drive ____ Pain when ejaculating ____ Premature ejaculation ___ Difficult ejaculation ____ Erectile dysfuncion ____ Peyronie's disease

Muscles, Joints, Bones & Nervous System

Do you have pain and tightness? ___ Yes ___ No If yes, where? (list all sites below)
_____

_____

The pain is (Check ALL that apply) ___ Sharp ___ Aching ___ Numb ___ Deep ___ Burning ___ Dull ___ Superficial ___ Tingling ___ Worse/Better with heat ___ Worse/Better with ice/cold
Does any particular movement make it Worse? _____ or Better?_____
Does rest improve it or make it worse _____

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Do you have (Check ALL that apply) ___ Swollen joints ___ Arthritis/Joint pain ___ Tendonitis ___ Rheumatism
___ Bone pain ___ Muscle cramping ___ Muscle pain ___ Repetitive strain injury
____Other (describe) _____
Have you ever had seizures? ___ Yes ___ No Concussion? ____Yes ___No
Do you have tingling or numbness any where ? If so, where _____

Respiratory, Eyes, Ears, Nose, Throat & Head

Do you smoke? ___Yes ___ No. If yes, # of cigarettes/day _____ for _____ years? Cigars? ___ Yes ___ No

Do you have (check ALL that apply) ___ Frequent colds ___ Chronic runny nose ___ Chronic cough
___ Nose bleeds ___ Pained/red/dry eyes ___ Poor vision ___ See spots ____ Dizziness ___Ringing in ears
___ Clogged/popping ears ___ Frequent sore throat ____ Upper respiratory problems
___ Cough up mucus If yes, how much? _____ Color of phlegm _____
___ Frequent headaches/migraines If yes, describe _____
_____

Other (describe) _____

Cardiovascular

Have you ever been diagnosed with heart trouble? ___ Yes ___ No
Have yu ever been diagnosed with high blood pressure ___ Yes ___No
Do you have (check ALL that apply) ___ Chest pain ___Palpitations ___ Varicose veins ___ Phlebitis
___ Cold hands/feet ___ Irregular heart beat ___ Poor circulation
___ Other (describe) _____

Emotions & Sleep

How do you feel emotionally? _____

Do you have (check ALL that apply) ___ Panic attacks ___ Depression ___ Anxiety ___ Bad temper
___ Nervousness ___ Fear attacks ___ Poor memory ___ Difficulty concentrating
___ Other (describe) _____

Describe your stress level ___ None ___ Low ___ Moderate ___ Severe. Do you use prescription/non-prescription substances? ____ Anti-depressants ___ Anti-anxiety meds ___ Sleeping pills
Other (list) _____
How long do you normally sleep? _____ hours per night
Do you have difficulty (check ALL that apply) ___ Falling asleep ___ Staying asleep ___ Disturbed sleep
___ Waking up at about ____ am/pm and not being able to fall back asleep because _____
_____
Other sleep problems (describe) _____

Urinary & Genital

How often do you urinate? ___ times/day Color: _____
Do you have (answer ALL that apply) ___ Trouble starting stream ___ Frequent urination ___ Incontinence
___ Pain ___ Trouble holding urine ___ Burning ___ Dribbling when sneezing ___ Urinary tract infections
___ Blood in urine ___ Kidney stones ___ Other (describe) _____

Skin & Hair

I have (check ALL that apply) ___ Dry skin ___ Skin rashes ___ Itching ___ Acne ___ Eczema ___ Hives
___ Hair loss ___ Premature gray hair ___ Other (describe) _____

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Family Medical History

Please list significant family illnesses:

Mother_____

Father_____

Siblings _____

Grandparents _____

What is your most important goal to achieve from your acupuncture treatment(s)?_____

_____

On the drawings below, please circle the areas where you have pain or discomfort.
Rate according to degree of discomfort using 1-5 (with 5 a the worst)