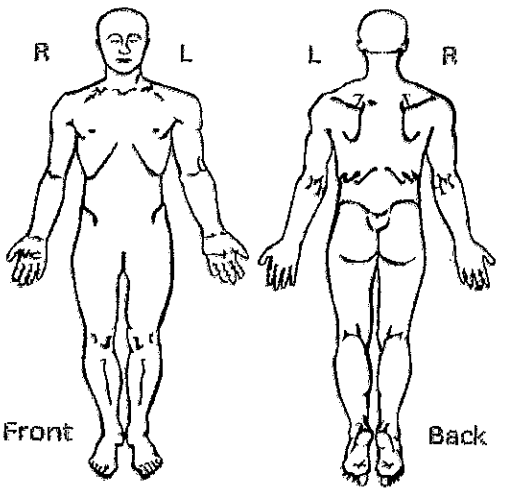
Acupunture Comprehensive Intake

Note: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without authorization.

Name: _____ Date: _____
Age: _____ DOB: _____ Gender: ☐ Male ☐ Female

Accident Information	
Is condition due to an accident?	☐ Yes ☐ No
Date	
Type of accident	☐ Auto ☐ Work ☐ Home ☐ Other
To whom have you made a report of your accident?	☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other
Attorney name (if applicable)	
Patient Condition	
Reason for visit	
When did your symptoms appear?	
Is this condition getting progressively worse?	☐ Yes ☐ No

Please Mark Your Areas of Pain



Rate sensitivity of pain from 1(less) to 10 (sev)	
Type of pain:	☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
How often do you have this pain?	
Is it constant or does it come and go?	
Does it interfere with your	☐ Work ☐ Sleep ☐ Daily ☐ Routine ☐ Recreation
Activities/movements that are painful to preform	☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
Health History	
What treatment have you already received?	☐ Medication ☐ Surgery ☐ Physical Therapy ☐ None ☐ Other
Name and Address of Doctor who have treated you	
Date of last	
Physical Exam	
Spinal X_Ray	
Blood test	
Spinal Exam	
Chest X-Ray	
Urine Test	
Dental X-Ray	
MRI, CT-Scan, Bone Scan	

Medical History			
Check all that apply	☐ AIDS/HIV	☐ Goiter	☐ Pneumonia
	☐ Alcohol Abuse	☐ Gonorrhea	☐ Polio
	☐ Allergies	☐ Gout	☐ Prostate
	☐ Anemia	☐ Heart Disease	☐ Prosthesis
	☐ Anorexia/Bulimia	☐ Hepatitis	☐ Psychiatric Care
	☐ Appendicitis	☐ Possible	☐ Rheumatoid Arthritis
	☐ Arthritis	☐ Herniated Disk	☐ Rheumatic Fever
	☐ Asthma	☐ Hernia	☐ Scarlet Fever
	☐ Bleeding Problem	☐ Herpes	☐ Stroke
	☐ Breast lump	☐ High Cholesterol	☐ Suicide Attempt
	☐ Bronchitis	☐ Kidney Diseases	☐ Thyroid Problems
	☐ Bulimia	☐ Liver Problems	☐ Tonsillitis
	☐ Cancer	☐ Measles	☐ Tuberculosis
	☐ Cataracts	☐ Migraines	☐ Tumors
	☐ Chemical Dependency	☐ Mononucleosis	☐ Growths
	☐ Chicken pox	☐ Multiple Sclerosis	☐ Typhoid Fever
	☐ Diabetes	☐ Mumps	☐ Ulcers
	☐ Emphysema	☐ Osteoporosis	☐ Vaginal Infections
	☐ Epilepsy	☐ Pacemaker	☐ Venereal Disease
	☐ Fractures	☐ Parkinson's Disease	☐ Whooping Cough
	☐ Glaucoma	☐ Pinched Nerve	☐ Other_____

General	
Are you or is there a chance you could be pregnant?	☐ Yes ☐ No
Due Date	
Acupuncture Social History	
Exercise	☐ None ☐ Moderate ☐ Daily ☐ Heavy
Work Activity	☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor
Habits	☐ Smoking ☐ Alcohol ☐ Coffee/Caffeine Drinks ☐ High Stress Level
Smokes: Packs/Day	
Alcohol: Drinks/Week	
Coffee: Cups/Day	
Stress Reason	

Surgical History	Since When	Doctor	Hospital
Fall			
Head Injuries			
Broken Bones			
Dislocations			
Surgeries			

Current Medication	
Skin	☐ Rash ☐ Itching
Heme-Immuno	☐ Fever ☐ Chills ☐ Swollen glands ☐ Easy bruising or bleeding ☐ Cancer ☐ HIV or AIDS

ENT	☐ Change In hearing ☐ Sore throat
Respiratory	☐ Cough ☐ Shortness of breath ☐ Coughing up blood ☐ Bronchitis ☐ Tuberculosis
Cardiovascular	☐ Chest pain ☐ Palpitations ☐ High blood presure ☐ Stroke
Gastro-intestinal	☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Blood In stool ☐ Constipation ☐ Loss of bowel control
Neurological	☐ Numbness ☐ Seizures
Constitutional	☐ Sweats ☐ Dizziness ☐ Unusual loss or gain of weight
Genito-urinary	☐ Blood in urine ☐ Pain on urination ☐ Loss of bladder control ☐ Kidney Problems
Eyes	☐ Blurry vision ☐ Loss of vision
Musculoskeletal	☐ Weaknes ☐ Osteoporosis
Endocrine	☐ Diabetes ☐ Hypothroidism

DO NOT WRITE BELOW THIS LINE

Height_____ Weight_____ Blood pressure_____