Acupuncture Intake Form

Welcome to Soaringsun Health and Acupuncture, LLC. Chinese Medical Diagnosis requires complete and honest answers to questions pertaining to bothe the body and the spiritual/emotional state as well. Thank you for taking the time to fill out this form completely.

All information will remain confidential

Name: Date of Birth:

Address:

Day Phone: Evening Phone: Cell:

Email address:

Emergency Contact:

Name:

Address:

Phone: Relationship:

Please describe the resason for your visit today (Chief complaint):

Is it getting better, worse, or staying the same?

Are you, or have you been, treated for this problem with any other health professionals?

Has it been effective?

What was your diagnosis?

Are you taking any medications or supplements? If so, which ones? (Add dosage if known)

Are you in generally good health, or do you frequently fall ill?

What illnesses might you be prone to? (i.e. frequent colds, gastrointestinal problems)

Medical History

Pleas circle any current health issues. For those diseases which are part of your health history, please note the year of occurrence.

Allergies	Epilepsy	Polio
Anemia	Fatigue	Scarlet Fever
Appendicitis	Gout	Stroke
Arteriosclerosis	Heart Disease	Thyroid Disorder
Asthma	Hepatitis (A, B, C)	Tuberculosis
Bleeding Disorder	Hypoglycemia	Ulcers
Blood Pressure (Low or High)	Injuries	Trauma (Falls, accidents)
Cancer	Insomnia	Surgeries (Please List)
Chicken Pox	Intestinal Parasites	
Diabetes	Multiple Sclerosis	
Digestive Disorders	Mumps	
Emotional Difficulties	Pacemaker	Other:
Emphysema	Weight Loss or Gain	

Do any of your family members suffer from: (Please list relation to you)

Alcholism	Diabetes	Stroke
Arteriosclerosis	Heart Disease	Allergies (please list):
Asthma	High Blood Pressure	
Cancer	Seizures	

Which of the following are part of your lifestyle? How frequently do you engage in it?

Alcohol	Nicotine	Exercise
Coffee	Recreational Drug Use	Excessive Sugar

How many meals do you eat a day?

Do you follow any particular diet?

On a scale of 1-10, how would you rate the level of stress in your life right now?

What is the level of stress in your life in general (1-10)?

How does stress affect you? (i.e. headaches, stomach pain)

Are there any other concerns you would like to address?

Review of Symptoms

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue. Please put **one check** next to the symptoms you have experienced, **two checks** next to symptoms you experience frequently, and **three checks** next to symptoms that particularly distress you.

Head and Face
Headaches
Dizziness
Memory loss
Other:

Nose
Frequent colds
Sinus trouble
Bleeding

Mouth
Dental problems
Gum problems
Teeth grinding/TMJ
Unusual tastes
Other:

Throat
Sore throat
Hoarseness
Difficulty swallowing
Dryness
Other:

Respiration
Difficulty inhaling
Difficulty exhaling
Pain
Cough
Congestion
Shortness of breath
Other:

Energy
High
Low

Heart and Chest
High blood pressure
Low blood pressure
Chest Pain
Chest tightness
Difficulty lying down
Other:

Circulation
Easy brusing
Easy bleeding
Cold limbs (hands or feet)
Reynaud's Syndrome
Other:

Gastrointestinal
Always thirsty
Never thirsty
Excessive appetite
Low appetite
Gas/bloating
Stomach or abdominal pain
Nausea
Diarrhea/loose stools
Constipation
Rectal bleeding
Colon problems
Other:

Urination
Frequent
Difficult
Painful
Nocturnal
Bleeding
Other:

Skin
Acne
Dryness
Moles that change
Lumps
Excessive sweating
Night sweats
Rarely sweat
Other:

Neurological
Nervousness/anxiety
Tremors
Numbness or tingling
Lack of coordination
Nerve pain
Other:

Sleep
Insomnia
Drowsiness
Excessive dreaming
Waking easily
Other:

Pain: Please describe

_____

_____

_____

_____

_____

Men Only

Do you experience any of the following:

Reduced libido
Excessive libido
Impotence

Premature ejaculation
Discharge
Genital/testicular pain

Urinary frequency

Other concerns:

Women Only

Are you, or could you be, pregnant?

If yes, how far along?

Number of pregnancies: Births: Abortions: Miscarriages:

What form of birth control do you use?

Do you have regular PAP smears? How often?

Age of first menses: Age of menopause, if applicable?

Do you bleed between periods? Do you bleed after intercourse?

Have you ever had any gynecological surgeries or any abnormal findings on any test?

Are your periods uncomfortable or painful, either emotionally or physically?

Is your cycle:

Short (less than 28 days) Long (28+ days) Varied Regular

Painful? If yes: Before During After

Do you bleed: Heavily Lightly Very little

Do you have clots: Early in the cycle? Or throughout?

Relative to the blood that comes from a wound, is your menstrual blood:
The same color? Or more: Pale Purple Red Brown

Do you have any of the following pre-menstrual symptoms? (Emotions are not judged in Chinese medicine, they are neither good nor bad. They are however, important diagnostic tools. Please answer

Irritability Depression Crying Rage
Nausea Cravings (if yes, for what?) Breast tenderness

Any other symptoms around the time of your period?

Are you experiencing any low or high sexual desires?

Do you have any concerns surrounding this?

Do you have any other gynecological concerns or complaints?

I have provided correct and complete information to the best of my knowledge.

Patient's or guardian's signature Date