

Acupuncture Healing Arts Center
733 East Main Street
Torrington, CT 06790
860.626.1167

PATIENT INTAKE FORM

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

STREET: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

CITY: _____ BIRTHDATE: _____ SEX: _____

STATE: _____ ZIP: _____ OCCUPATION: _____

EMPLOYER'S NAME & ADDRESS: _____

MARITAL STATUS: _____ NUMBER OF CHILDREN: _____

PERSONAL PHYSICIAN: _____

DATE OF LAST PHYSICAL EXAMINATION: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

REFERRED BY: _____

Acupuncture has been explained to me as a treatment consisting of the insertions of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders. I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms.

SIGNED: _____ DATE: _____

FAMILY MEDICAL HISTORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High or Low Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> TB | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Spinal Problems | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Drug Addiction |

OTHER: _____

AGE PARENTS DIED: Mother: _____ Father: _____

ALL SURGERIES, ILLNESSES, DISEASES, ACCIDENTS: _____

CONTAGIOUS DISEASES (Check if you have ever had one of the following):

- HIV+ AIDS Hepatitis Venereal Disease Herpes Other

ALLERGIES (Drug, chemicals, food, animal, seasonal, etc.): _____

MEDICATIONS PRESENTLY TAKING (including herbs, vitamins, homeopathic, etc.):

LIFESTYLE

HABITS:

- | | | |
|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Soft Drinks | <input type="checkbox"/> Salt |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Recreational Drugs |
| <input type="checkbox"/> Black Tea | <input type="checkbox"/> Sugar | <input type="checkbox"/> Stress |

EXERCISE: Never Little Moderate Heavy

EMOTIONALLY:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Easily Irritable | <input type="checkbox"/> Difficult Making Decisions |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Cry Easily | <input type="checkbox"/> Hurry To Do Things |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stressed | <input type="checkbox"/> Restless |

DIET:

- | | | | | |
|----------------------------------|---------------------------------|-------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Beef | <input type="checkbox"/> Eggs | <input type="checkbox"/> Cheese | <input type="checkbox"/> Grains | <input type="checkbox"/> Tofu |
| <input type="checkbox"/> Pork | <input type="checkbox"/> Bread | <input type="checkbox"/> Margarine | <input type="checkbox"/> Fried Foods | <input type="checkbox"/> Yogurt |
| <input type="checkbox"/> Poultry | <input type="checkbox"/> Milk | <input type="checkbox"/> Ice Cream | <input type="checkbox"/> Sweets | <input type="checkbox"/> Health Foods |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Butter | <input type="checkbox"/> Vegetables | <input type="checkbox"/> Salads | <input type="checkbox"/> Spicy Food |

OTHER: _____

CRAVINGS: _____

Do you eat three meals per day? _____ Do you eat regular hours? _____

APPETITE:

___ Up and Down ___ Underweight ___ Good ___ Often Hungry ___ Loss of Taste

WEIGHT:

___ Normal ___ Underweight ___ Overweight ___ Recent Gain ___ Recent Loss

ENERGY:

___ Up and Down ___ Low ___ Normal ___ Excess ___ Low after Eating ___ Tired in Afternoon

MAJOR COMPLAINT, INJURY, OR ILLNESS: _____

DATE BEGAN: _____ DESCRIBE CAUSE OR HOW IT STARTED: _____

HAVE YOU EVER HAD THIS CONDITION OR SIMILAR CONDITION BEFORE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? _____

IF YES, WHEN? _____ BY WHOM? _____

WHAT WAS THE DIAGNOSIS? _____

WHAT WERE THE RESULTS OF THE TREATMENT? _____

THE CONDITION HAS GOTTEN: ___ BETTER ___ WORSE ___ SAME

WHAT MAKES IT BETTER? _____

WHAT MAKES IT WORSE? _____

GENERAL SYMPTOMS

BODY TEMPERATURE:

___ Warm Natured ___ Flushed Face ___ Feel Warmer Late Afternoon & Night
___ Cold Natured ___ Warm Palms ___ Alternate Chills & Fever
___ Cold Hands & Feet ___ Warm Soles ___ Normal

OTHER: _____

PERSPIRATION:

Very Little Easily Night Sweats
 Profuse Palms Bad Smell
 Without Exertion Feet Normal

OTHER: _____

DIGESTION:

Indigestion Nervous Stomach Bloating Normal
 Heartburn Nausea/Vomiting Full Feeling of Distension
 Belch or Burp Stomach Noises Abdominal Pain or Cramps
 Gas Bad Breath Difficulty Digesting Fatty/Oily Foods

OTHER: _____

NAILS:

Soft Ridges & Lines Pale Grow Slowly Break Easily
 Spots Normal Purple Grow Fast

EYES:

Wear Glasses or Contacts Eyelids Swollen Cataracts Red
 Spots or Lines in Vision Inflammation Glaucoma Dry
 Pale Under Eyelids Yellow Sclera Blink Itch
 Poor Night Vision Failing Vision Twitch Pain
 Sensitive to Light Sty History Strain Normal
 Color Blindness Blurry Vision Tear Easily

OTHER: _____

EARS:

Poor Hearing Ringing (High Pitch) Discharges
 Earaches Ringing (Low Pitch) Normal

OTHER: _____

NOSE:

Stuffy Nose Hay Fever Sneeze Often Environmental Sensitivity
 Mucous Bleeding Loss of Smell Blow Nose Often
 Sinusitis Rhinitis Normal

OTHER: _____

MOUTH & THROAT:

Dry Gum Problems Hoarseness
 Frequent Sore Throats Sores in Mouth/Tongue Frequent Colds
 Difficulty Swallowing TMJ Dry Cracked Lips
 Thyroid Problems Hiccups Drool Often
 Swollen Glands Grind Teeth Normal
 Feel Lump in Throat Teeth Problems

OTHER: _____

RESPIRATORY:

- | | | |
|--|---|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Difficulty Inhaling | <input type="checkbox"/> Dry Cough |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty Exhaling | <input type="checkbox"/> Cough with Phlegm |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty Breathing When Lying Down | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cough Often | <input type="checkbox"/> Cough with Blood |
| <input type="checkbox"/> Chest Tightness | <input type="checkbox"/> Sigh Often | <input type="checkbox"/> Normal |

OTHER: _____

BOWELS:

- | | | |
|---|---|---|
| <input type="checkbox"/> Loose Stool | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Undigested Food in Stool |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stool with Bad Smell |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Anus Itch | <input type="checkbox"/> Mucous in Stool |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Burning Anus | <input type="checkbox"/> Small Amount of Stool |
| <input type="checkbox"/> Black Stool | <input type="checkbox"/> Hard Stool | <input type="checkbox"/> Intestinal Worms |
| <input type="checkbox"/> Pain of Cramps | <input type="checkbox"/> Use Laxatives | <input type="checkbox"/> Normal |

OTHER: _____

URINATION:

- | | | | |
|------------------------------------|----------------------------------|---|--|
| <input type="checkbox"/> Frequent | <input type="checkbox"/> Burning | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Nighttime | <input type="checkbox"/> Blood | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Kidney Stones or Infections |
| <input type="checkbox"/> Profuse | <input type="checkbox"/> Pus | <input type="checkbox"/> Strong Smell | <input type="checkbox"/> Cloudy |
| <input type="checkbox"/> Scanty | <input type="checkbox"/> Painful | <input type="checkbox"/> Not Normal Color | <input type="checkbox"/> Normal |

OTHER: _____

THIRST:

- | | | |
|---|---|--|
| <input type="checkbox"/> Less Than Normal | <input type="checkbox"/> Excessive | <input type="checkbox"/> Prefer Hot Drinks |
| <input type="checkbox"/> Thirsty But Do Not Drink | <input type="checkbox"/> Prefer Cold Drinks | <input type="checkbox"/> Normal |

OTHER: _____

SLEEP:

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Lots of Dreams | <input type="checkbox"/> Tired When Getting Up in Morning |
| <input type="checkbox"/> Awake Easily | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Difficulty Going Back to Sleep |
| <input type="checkbox"/> Sleep Too Much | <input type="checkbox"/> Restless | <input type="checkbox"/> Normal |

OTHER: _____

HEADACHES – DIZZINESS:

- | | | | |
|---------------------------------------|--|--|---------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Bend Down, Stand Up & Get Dizzy | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Poor Balance | |
| <input type="checkbox"/> Faint Easily | <input type="checkbox"/> Migraines | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Normal |

OTHER: _____

SKIN:

- | | | | |
|----------------------------------|----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Boils | <input type="checkbox"/> Yellow Skin |
| <input type="checkbox"/> Oily | <input type="checkbox"/> Hives | <input type="checkbox"/> Body Odor | <input type="checkbox"/> Normal |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Pimples | <input type="checkbox"/> Clammy | |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Moles | <input type="checkbox"/> Bruise Easily | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Warts | <input type="checkbox"/> Cuts Heal Slowly | |

OTHER: _____

HAIR:

- | | | | | | |
|------------------------------|-------------------------------|-----------------------------------|--------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Oily | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Falling Out | <input type="checkbox"/> Early Grey | <input type="checkbox"/> Normal |
|------------------------------|-------------------------------|-----------------------------------|--------------------------------------|-------------------------------------|---------------------------------|

OTHER: _____

CARDIOVASCULAR – CIRCULATION:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diagnosed Heart Problems | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Broken Blood Vessels |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Bleed Easily | <input type="checkbox"/> Purple Palms & Fingers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Facial Swelling |
| <input type="checkbox"/> History of Anemia | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hand Swelling |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Extremity Numbness | <input type="checkbox"/> Normal |

OTHER: _____

PAIN:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Hands or Wrists | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Hips | <input type="checkbox"/> Muscle Twitching or Spasm |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Knees | <input type="checkbox"/> Damp Weather |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Foot or Ankle | <input type="checkbox"/> Nerve |
| <input type="checkbox"/> Spine | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Flank Area |

OTHER: _____

ANY OTHER PROBLEMS THAT YOU WOULD LIKE TO DISCUSS: _____

FOR MALES ONLY: (Please check or explain if applicable):

- | | |
|---|-------|
| <input type="checkbox"/> Reduced Sex Drive | _____ |
| <input type="checkbox"/> Premature Ejaculation | _____ |
| <input type="checkbox"/> Seminal Emission | _____ |
| <input type="checkbox"/> Impotence | _____ |
| <input type="checkbox"/> Discharges | _____ |
| <input type="checkbox"/> Genital Pain | _____ |
| <input type="checkbox"/> Prostrate Problems | _____ |
| <input type="checkbox"/> Pain or Burning upon Urination | _____ |
| <input type="checkbox"/> Dribble Urine | _____ |

If you are male, congratulations. You have just completed this form. If you are female, please continue filling out the next two pages.

FOR FEMALES ONLY:

ARE YOU OR MIGHT YOU BE PREGNANT? ___ YES ___ NO ___ MAYBE

IF YES, APPROXIMATE DATE OF CONCEPTION: _____

ARE YOU EXPERIENCING REDUCED SEX DRIVE? ___ YES ___ NO

OTHER DIFFICULTIES: ___ YES ___ NO

EXPLAIN: _____

DO YOU HAVE REGULAR PAP TESTS? ___ YES ___ NO

HOW REGULAR? _____

DO YOU HAVE REGULAR BREAST EXAMS? ___ YES ___ NO

HOW REGULAR? _____

DO YOU HAVE EXCESS BODY HAIR? ___ YES ___ NO

MENSTRUAL CYCLE:

HOW MANY DAYS FROM THE BEGINNING OF YOUR PERIOD TO THE START OF YOUR NEXT PERIOD? _____

(Please check and explain as applicable):

___ Irregular _____

___ Painful _____

___ Heavy Flow _____

___ Scanty Flow _____

___ Dark Color Flow _____

___ Light Color Flow _____

___ Clotting _____

___ Water Retention _____

___ Abdominal Bloating _____

___ Painful or Tender Breasts _____

___ Breast Lumps _____

___ Emotional Changes _____

___ Spotting Between Periods _____

___ Lump in Throat Feeling _____

___ Constipation and/or Diarrhea _____

___ Tightness in Chest _____

___ Hormonal Problems _____

___ Backache _____

___ Sigh Often _____

