PATIENT INTAKE FORM

This is a confidential questionnaire to help us determine the best treatment plan for you. If you have any questions, please feel free to ask. Thank you

Last First Middle

Name: _____ Date: _____

Address: _____ S.S. #: _____

E-mail: _____ Home Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Marital Status: M___ S___ D___ W___ Sex: M/F _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Who should we thank for referring to this office? How did you hear about us? _____

Have you received acupuncture therapy before Y N (date) _____ (Acupuncturist) _____

What are your main complaints that brought you to this office? Please provide a brief history.

#1 _____

#2 _____

Do you have any other health conditions that causing you worry or discomfort?

_____

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

_____

_____

List any medications and supplements you are currently taking (indicating a reason).

_____

Do you have any known allergies, and to what? _____

_____

When and where were you last seen by a medical doctor?

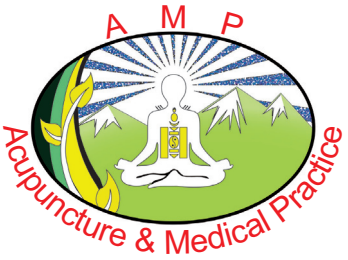
Name of physician: _____ Date: _____

Reason for visit: _____ Diagnosis: _____

Have you ever had or do you now have...	Yes	No
HIV Positive		
Hepatitis B or C		
Heart Attack		
Heart Pacemaker		
High Blood Pressure		
Tendency to Bleed or Bruise Easily		
Stroke		

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

____ Cancer ____ Tuberculosis ____ Diabetes ____ Hypertension ____ HIV Positive ____ Hepatitis



What type of care do you desire?

_____ temporary relief of symptoms/pain control.
_____ eradication of tendencies causing your condition.
_____ balanced optimum healthcare, elimination of root cause of problem, if possible.
_____ maintenance care/balance to stay in good health.

How would you classify your condition?

_____ minor _____ severe/worsening
_____ involved _____ serious

On a scale of 1-10, how would you rate how your health problem affects your life?
(1 is no problem, 10 is major problem) _____

What other therapies have you tried for this condition?
_____.

Lab results: (please include copies, if available_____
_____.

List one adjective/word to describe your life_____.

Please indicate the use and frequency of the following?

tobacco _____
coffee/black tea _____
alcohol _____
non-medical drugs _____
exercise _____

How do you feel about the following areas of your life?
Please check appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Comments
Spouse						
Family						
Diet						
Sex						
Self						
Work						
Exercise						
Spiritually						