清 Great Spirit Acupuncture

General Patient Information

Last Name _____ First Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Address _____
(street) (city) (state) (zip)

Height _____ Weight _____ Date of Birth _____ Age _____ Gender _____

Occupation _____ How long at currrent job? _____ Enjoy work? ☐ Yes ☐ No

Marital Status _____ Spouse's Name/Contact Info _____

Do you have children? _____ If so, how many? _____

Name of Emergency Contact Person _____

Phone Number for Emergency Contact Person _____

Your Primary Care Physician _____

Who can we thank for referring you? _____

Please describe your chief complaint _____

Does it come and go or is it constant? _____ How long have you had condition? _____

Is there anything that relieves your chief complaint? _____

Is there anything else you would like addressed today? _____

FOR OFFICE USE ONLY

ICD-9 CODE(S): _____ DATE OF FIRST TREATMENT: _____

CPT CODE(S): _____

Personal Health Intake Form

How are you feeling today? _____

How is your energy level? _____

Have you had acupuncture before? _____ If so, when & by whom? _____

Are you afraid of needles? _____

Have you eaten today? _____ If so, what and what time? _____

What is your overall wellness goal? _____

_____

How would you like me to assist with this goal? _____

_____

Do you have expectations for today's visit? _____

_____

Please list any illnesses/diseases that run in your family:

Mother/Grandmother	Father/Grandfather
_____	_____
_____	_____
_____	_____
_____	_____

HOSPITALIZATIONS/SURGERIES/ACCIDENTS: _____

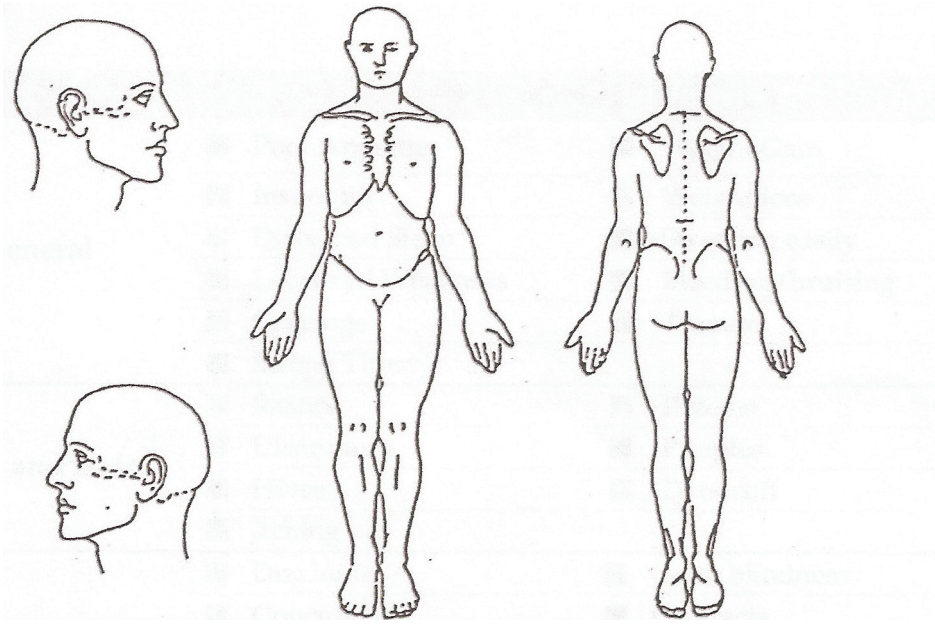
_____

_____

ALLERGIES: _____

_____

PLEASE MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS BELOW



Symbol	Reaction
PAIN	
X	little
XX	moderate
XXX	strong
SWELLING	
^	slight
^^	moderate
^^^	severe
PULSING	
O	slight
OO	moderate
OOO	strong
WEAKNESS/TEMP.	
~	weak
+	hot
SKIN PROBLEMS	
*	skin issue

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (e.g. climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (workout/recreation less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (workout/recreation 4x/week for 30 min.)

Please describe your exercise regimen:

_____

_____

Please list drugs, herbs and supplements you currently take:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Current Physical Symptoms

General

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sweating easily
- ☐ Bleeding/bruising
- ☐ Tremors
- ☐ Night sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop
- ☐ Poor Balance

Skin & Hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples/Acne
- ☐ Dandruff
- ☐ Recent moles
- ☐ Changes in hair texture
- ☐ Hair loss

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Photophobia
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision/Glaucoma
- ☐ Earaches
- ☐ Ringing in the ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ TMJ
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches
- ☐ Jaw clicks
- ☐ Gum/teeth problems

Cardio-vascular

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Tightening in chest
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Palpitations
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis
- ☐ Stroke

Do you have a pacemaker? ☐ Yes ☐ No

Respiratory

- ☐ Cough
- ☐ Asthma/Allergies
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Frequent colds or flu
- ☐ Excessive phlegm

Gastro-intestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas/bloating
- ☐ Parasites
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Diverticulitis
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Chronic laxative use
- ☐ Chron's
- ☐ Colitis

Do you follow a special diet tailored to your needs? ☐ Yes ☐ No

Current Physical Symptoms (cont.)

Genito-urinary	☐ Pain on urination	☐ Incontinence	☐ Sores on genitals
	☐ Low to no sex drive	☐ Decrease in flow	☐ Impotence/frigidity
	☐ Blood in urine	☐ Kidney stones	
Musculo-skeletal	☐ Neck pain	☐ Back pain	☐ Hand/wrist pain
	☐ Muscle pain	☐ Muscle weakness	☐ Shoulder pain
	☐ Knee pain	☐ Foot/ankle pain	☐ Hip pain
	☐ Sciatica	☐ Tinnitus	☐ Arthritis
	☐ Migraines	☐ Varicose veins	
Neuro-psycholog-ical	☐ Seizures	☐ Poor memory	☐ Anxiety
	☐ Dizziness/Vertigo	☐ Depression	☐ Bad temper
	☐ Loss of balance	☐ Concussion	☐ Frequent mood swings
Other Illness	☐ HIV positive	☐ Rheumatic fever	☐ Eating disorder
	☐ AIDS	☐ Hypoglycemia	☐ Jaundice
	☐ Epstein-Barr/Mono	☐ Diabetes	☐ Hepatitis
	☐ Herpes 1 or 2	☐ Lupus	☐ Under/Overweight

Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
	Number of meals you eat in an average day:		
	Describe daily diet:		
Caffeine	# of cups/day ☐ Coffee _____ ☐ Tea _____ ☐ Cola _____ ☐ Energy Drinks ___		
Tobacco	☐ Tobacco Type? _____ ____ packs per day # of years _____		
	Did you quit? _____ If so, when? _____		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If so, how many drinks per week? _____		
Mental Health	Is stress a major problem for you?	☐ Yes	☐ No
	Do you feel depressed?	☐ Yes	☐ No
	Do you panic when stressed?	☐ Yes	☐ No
	Do you have problems with eating or your appetite?	☐ Yes	☐ No
	Do you cry frequently?	☐ Yes	☐ No
	Have you ever attempted suicide or is there family history?	☐ Yes	☐ No
	Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
	Do you have trouble sleeping? Is it dream disturbed?	☐ Yes	☐ No
	Have you ever been to a counselor?	☐ Yes	☐ No

Do you have a history of alcohol/drug abuse? If so, please explain.

_____

_____

_____

Is there a family history of alcohol/drug abuse? _____

For Women Only

Age at onset of menstruation: _____ Date of last period: _____		
Period occurs every _____ days How many days does period run? _____		
Number of pregnancies _____ live births _____ miscarriages _____ abortions _____		
Is there a chance you may be pregnant?	☐ Yes	☐ No
Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes	☐ No
Do you or have you breastfed your children?	☐ Yes	☐ No
Have you had a D&C, hysterectomy or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder or kidney infections within the last year?	☐ Yes	☐ No
Do you get yeast infections often or at all?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around the time of your period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps or nipple discharge?	☐ Yes	☐ No

For Men Only

Do you urinate often? _____ If so, is it clear, copious, dark, yellow, scanty?		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder or prostate infections within the last year?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Have you been diagnosed to be sterile?	☐ Yes	☐ No
Have you had a vasectomy?	☐ Yes	☐ No

Patient Signature: _____ Date: _____

Attending Acupuncturist: _____ Date: _____