Classical Herbs and Acupuncture
Patient Intake Form & Health History

Today's Date	
Patient Name	
Address	
Home Phone	
Mobile or Work Phone	
Email address	
Emergency Contact (name, relationship, phone number)	
Date of Birth (mm/dd/yyyy)	
Gender	
Height	
Weight	
Referred by	
Health History	
Reason for today's visit	
Have you had acupuncture or Chinese Herbal Medicine?	
Therapies tried for this problem	___ diet modification ___ vitamin/mineral ___ herbs ___ homeopathy ___ chiropractic ___ conventional drugs ___ other
Duration of condition	
Is it getting worse?	
Does it bother you to:	___ Sleep ___ Work ___ Other
Initial cause/onset	

Are you now under the care of a physician? If yes, for what?	
Physician Name	
Physician Phone	
Laboratory procedures performed	___ stool analysis ___ blood & urine analysis ___ hair analysis ___ other
Outcome	
Current medications:	
Major hospitalizations, surgeries, injuries, etc.	
Do you have	___ corrective lenses ___ dentures ___ hearing aid ___ medical device/prosthetics/implant Describe:
Current stress level	Low 1 2 3 4 5 6 7 8 9 10 High
Major causes of stress	___ Work ___ Residence ___ Finances ___ Legal ___ Relationships ___ Other
Is your job associated with	___ pesticides ___ radioactivity ___ solvents ___ physical danger
Recent changes in	___ sight ___ hearing ___ taste ___ smell ___ mobility ___ sleep patterns ___ sensation (hot/cold)
Time of day you feel	best/most energy _____ worst/least energy _____

Do you experience any of these symptoms every day or most days?	___ bleeding ___ diarrhea ___headaches ___ chronic pain/inflammation ___ disinterest in eating ___insomnia ___ constipation ___ disinterest in sex ___ itching/rash ___ fatigue ___ dizziness ___ low fever ___ depression ___ fecal incontinence ___nausea ___ panic attacks ___ urinary incontinence ___ vomiting ___ shortness of breath ___ other:
Your medical history (circle all that apply)	AIDS/HIV Alcoholism/drug addiction Allergies Alzheimer's disease Appendicitis Arteriosclerosis Arthritis Asthma Autoimmune disease Birth trauma (your own birth) Bleed or bruise easily Bodily heaviness Bronchitis Cancer (specify) _____ Carpal tunnel syndrome Chicken pox Chills Cholesterol, elevated Chronic fatigue syndrome Circulatory problems Cold hands or feet Colitis Dental problems Depression Diabetes Diverticular disease Eating disorder Emphysema Environmental sensitivities Epilepsy Eyes, ears, nose, throat problems Fatigue Fever Fibromyalgia Food intolerance Gastroesophageal reflux disease Genetic disorder Glaucoma Goiter Gout Heart disease Heavy sleep Hepititis Herpes High blood pressure Infection, chronic Insomnia or narcolepsy Irritable bowel syndrome Kidney or bladder disease Lack of strength Learning disabilities Liver or gallbladder disease (stones) Major trauma (car, falls, etc.) Measles Mental illness Mental retardation Migraine headaches Multiple sclerosis Mumps Muscle cramps Neurological problems (Parkinson's, paralysis) Night sweats and/or peculiar taste (describe) _____ Obesity Osteoporosis Pacemaker Pleurisy Pneumonia Polio Poor circulation Poor sleep Recent weight loss/gain Rheumatic fever Scarlet fever Seasonal affective disorder Seizures Sexually transmitted disease Shortness of breath Stroke Sweat easily Thyroid disorder Tuberculosis Typhoid fever Ulcers Urinary tract infection Varicose veins Vertigo/dizziness Whooping cough Other _____
Men's medical history (circle	BPH Infertility

all that apply)	Decreased sex drive Prostate Cancer Other _____
Women's medical history (circle all that apply)	Breast cancer Decreased sex drive Endometriosis Fibrocystic breast(s) Fibroids/ovarian cysts Birth control _____ Infertility Mammogram (results: _____) Menopause Surgical menopause Pelvic inflammatory disease Vaginal infection(s) PMS Pregnant Length of last menstrual cycle Interval of time between menstrual cycles Recent changes in menstrual flow (heavier, large clots, etc.) Other _____
Diet and exercise	Typical diet _____ Exercise frequency _____ Exercise duration _____ Exercise intensity _____ Form of exercise _____
Head, Eyes, Ears, Nose, and Throat (circle all that apply)	Glasses/contacts Eye strain Eye pain Red eyes Itchy eyes Spots in eyes Poor vision Blurred vision Night blindness Glaucoma Cataracts Teeth problems Grinding teeth TMJ Gum problems Dry mouth Excessive saliva Sinus problems Excessive phlegm Color of phlegm _____ Facial pain Sores on lip/tongue Recurrent sore throat Swollen glands Lumps in throat Enlarged thyroid Nose bleeds Ringing in ears Poor hearing Earaches Headaches Migraines Concussions Other head/neck problems _____
Respiratory (circle all that apply)	Difficulty breathing when lying down Shortness of breath Tight chest Asthma/wheezing/coughing blood Cough: wet/dry thick/thin Pneumonia
Cardiovascular (circle all that apply)	High blood pressure Blood clots Low blood pressure Fainting Chest pain Difficulty breathing Tachycardia Heart palpitations

	Phlebitis	Irregular heartbeat
Gastrointestinal (circle all that apply)	Nausea Acid regurgitation Hiccup Bad breath Constipation Black stool Mucous in stool Itchy anus Rectal pain Anal fissure	Vomiting Gas Bloating Diarrhea Laxative use Bloody stool Intestinal pain or cramping Burning anus Hemorrhoid
Bowel Movement	Frequency _____ Color _____ Texture/form _____ Odor _____	
Musculoskeletal (circle all that apply)	Neck/shoulder pain Upper back pain Joint pain Limited range of motion Other _____	Muscle pain Lower back pain Rib pain Limited use
Skin & Hair (circle all that apply)	Rashes Eczema Acne Dandruff Hair loss Change in hair/skin texture Other hair/skin problems _____	Hives Psoriasis Ulcerations Itching Fungal infections
Neuropsychological (circle all that apply)	Seizures Tics Depression Irritability Abuse survivor Seeing a therapist Other _____	Numbness Poor memory Anxiety Easily stressed Considered/attempted suicide
Genito-urinary (circle all that apply)	Pain on urination Urgent urination Unable to hold urine Venereal disease Wake to urinate Decreased libido Impotence Nocturnal emission	Frequent urination Blood in urine Incomplete urination Bedwetting Increased libido Kidney stone(s) Premature ejactulation