Ohio Acupuncture Center

Intake Form

Name Last: _____First: _____SSN #_____ / _____ /_____

Date of Birth_____ /_____ /_____ **Gender** F ____M _____ **Email** _____

Address _____City _____State _____Zip Code_____

Telephone: Home (_____) _____-_____ Work (_____) _____-_____Ext._____

Marital Status: _____**Education** (Highest grade or degree achieved)_____

Option: Height _____ Weight _____ HIV _____ HbsAg _____

How did you hear about our clinic?_____

Have you been treated by Acupuncture or Oriental medicine before? _____

Name of your physician:_____Tel:_____

Address of your physician: _____City _____State _____Zip Code_____

In an Emergency Notify Name_____ Relationship to client_____

Phone (Day) (_____)_____-_____(Evening) (_____)_____-_____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1. Main problem you would like us to help you with: _____
2. How long ago did this problem begin? _____
3. Have you been given a diagnosis for this problem? If so, what? _____
4. What kinds of treatment have you tried? _____
5. Are you currently receiving treatment for your problem? _____If so, please describe: _____
6. Does anything improve your problem? _____

Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

_____ _____ / _____ / _____

Patient's signature (Parent or Guardian if under 18) **Date**

PAST MEDICAL HISTORY

Illnesses: _____

_____

Surgeries_____

_____

Significant Trauma (Auto accidents, falls, etc.) _____
Do you have, or have you ever had, any **Infectious Diseases**? Yes ☐ No ☐
If so, please describe: _____

Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

_____

_____

Allergies:

_____

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side _____
Father's Side _____
Siblings _____
If any of the above is deceased, what was the cause? _____

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) _____
Childhood health _____
Location of upbringing (Geographically prone to certain diseases, habits, etc.) _____
Current Emotional Health _____
Current Quality of Life_____
Current Relationship/Quality_____
Current Predominant Emotiom_____
Occupation _____Stress Level_____
Have you had any unusual stresses recently? _____
Favorite time of year (body type) _____ Worst_____
Hobbies & Recreational Habits _____
Do you have a regular exercise program? Yes ☐ No ☐ If so, please describe: _____
Have you traveled abroad in the past year? Yes ☐ No ☐ Where? _____
If applicable, please describe smoking or alcohol intake : _____

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Areas of Numbness	☐ Anxiety
☐ Concussion	☐ Lack of Coordination	☐ Poor Memory
☐ Dizziness	☐ Loss of Balance	☐ Easily Angered
☐ Headaches	☐ Fainting	☐ Depression
☐ Migraines	☐ Disorientation	☐ Mania
☐ Easily Susceptible to Stress		

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____
Any nervous habits? _____

PREGNANCY & GYNECOLOGY

___Age at First Menses
___Period between Menses
___Duration of Menses
☐ Unusual Character
☐ Heavy or ☐ Light
☐ Irregular Periods
☐ Painful Periods

__ Number of Pregnancies
__ Number of Births
__ Miscarriages
__Abortions
☐ Difficult Births
☐ Breast Lumps
☐ Clots

☐ Birth Control?
What type? _____
How long?_____
☐ Fertility Problems
☐ Vaginal Discharge
☐ Vaginal Sores

First Date of Last Menstrual Cycle _____/_____/_____ Date of Last Pap Smear _____/ _____/ _____
Do you experience changes in Body and/or Psyche prior to menstruation? _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

☐ Fevers
☐ Chills
☐ Fatigue
☐ Tremors
☐ Seizures
☐ Night Sweats
☐ Change in Appetite
☐ Peculiar tastes or smells
☐ Sudden energy drops?

What time of Day? _____

☐ Poor Sleep/ Insomnia
☐ Dream Disturbed Sleep
☐ Depression
☐ Mania
☐ Emotional Changes
☐ Day Sweating
☐ Poor Balance
☐ Weight Loss
☐ Weight Gain
☐ Poor Appetite
☐ Strong thirst for Hot or Cold drinks?
☐ Headaches
☐ Localized Weakness
☐ Bleeding or Bruising
☐ Joint Pain

CARDIOVASCULAR

☐ High blood pressure
☐ Irregular heartbeat
☐ Low blood pressure
☐ Chest pain
☐ Dizziness
☐ Fainting
☐ Cold Sweats
☐ Swelling of Feet
☐ Swelling of Hands
☐ Difficulty in Breathing
☐ Cold Hands/Feet
☐ Phlebitis
☐ Blood Clots
☐ Palpitations

RESPIRATORY

☐ Cough
☐ Asthma
☐ Easily Winded w/ Exertion when laying down
☐ Production of phlegm
☐ Pain w/ Deep Breaths
☐ Bronchitis
What Color? _____
☐ Difficulty in Breathing
☐ Shortness of Breath
☐ Coughing Blood

GASTROINTESTINAL

☐ Nausea
☐ Vomiting
☐ Indigestion
☐ Ulcers
☐ Hernia
☐ Abdominal Pain/ Cramps
☐ Parasites
☐ Belching
☐ Bad Breath
☐ Hemorrhoids
☐ Digestive Disorders
☐ Constipation
☐ Diarrhea
☐ Blood in Stools

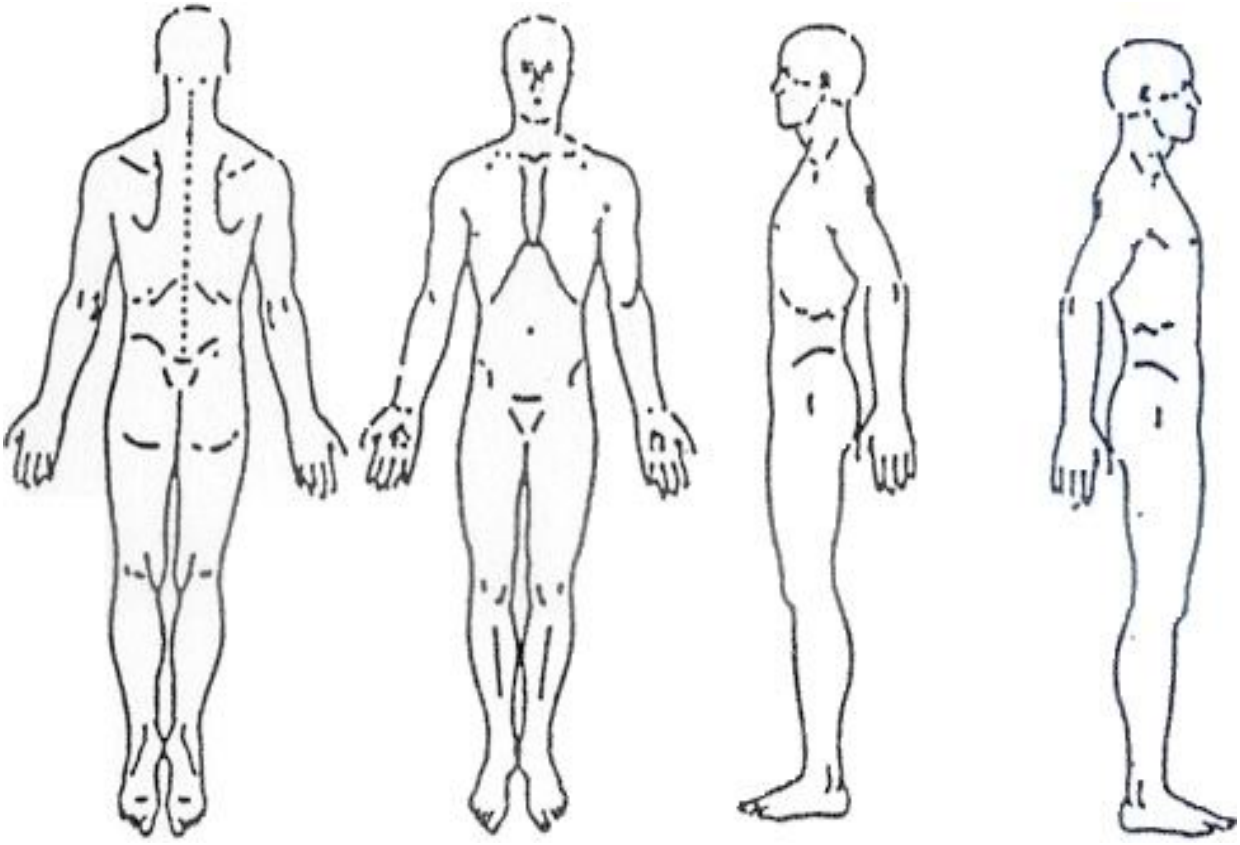
GENITO-URINARY

☐ Pain on Urination
☐ Urgent Urination
☐ Frequent Urination
☐ Unable to Hold Urine
☐ Decrease in Urine
☐ Blood in Urine
☐ Impotency/ Infertility
☐ Genital Sores
☐ Kidney sores
☐ Waking up to Urinate
How often? _____

MUSCULOSKELETAL

- ☐ Muscular Weakness
- ☐ Muscle Cramps
- ☐ Injuries or Falls
- ☐ General Aches
- ☐ Arthritis
- ☐ Spasms
- ☐ Muscular Atrophy
- ☐ Joint Instability
- ☐ Recent Sprains

Please circle on the diagram any areas of any type of pain or injury.



Please try to describe the type and quality of the pain _____

Are there any other internal organ or systemic dysfunctions that we should be aware of? _____

_____

Are there any other problems you would like to discuss? _____

_____