China Spring
Acupuncture & Herbal Medicine

Acupuncture Intake Form

Name _____ **Gender** ☐F ☐M **Date of Birth** ____/ ____/ _____

Address _____ **Email**_____

Occupation _____ **Telephone** _____

Emergency Contact _____ **Telephone** _____

Primary Physician _____ **Telephone**_____

Referred by _____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

Main Concern_____

How long does this problem last?_____

Have you been given a diagnosis for this problem? If so, what?_____

Other Current Therapies: ☐Western Medicine ☐Acupuncture ☐Herbs ☐Massage ☐Physical Therapy ☐Chiropractor ☐Reiki ☐Homeopathy ☐Other:_____

PRIOR MEDICAL HISTORY

Illnesses: ☐ Cancer ☐ Diabetes ☐ HBP ☐ Heart Disease ☐ Hepatitis ☐ Seizers ☐Asthma ☐ Rheumatic Fever ☐ Thryroid Disease ☐Venereal disease

Surgeries: _____

Significant Trauma (auto accidents, falls, etc.):_____

Medications: (prescription and OTC drugs, supplements, herbs. Taken within the last three months)_____

Allergies: _____

HABITS

Exercise(type)_____ Times per week_____

☐ Cigarettes ☐ Alcohol ☐ Coffee ☐ Soda ☐ Sugar ☐ Salt ☐ Drugs ☐Tea Other _____

Breakfast:_____Lunch:_____Dinner:_____

FAMILY MEDICAL HISTORY

☐Asthma ☐Allergies ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Heart disease ☐ High Blood Pressure ☐Seizures ☐Thyroid ☐Hepatitis ☐Rheumatic Fever ☐Thyroid disease ☐Other:_____

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

- ☐ Fevers ☐ Chills ☐ Fatigue ☐ Sweat easily
- ☐ Poor sleeping ☐ Night sweats ☐ Weight loss ☐ Cravings
- ☐ Weight gain ☐ Change in appetite ☐ Strong thirst for: ☐ Hot drinks ☐ Cold drinks
- ☐ Sudden energy drop, if so what time of day?_____
- ☐ Bleed or bruise easily ☐ Peculiar tastes or smells

MUSCULOSKELETAL:

□ Neck pain □ Rotator cuff □ Knee pain □ Foot/ankle pain
□ Muscle pain □ Muscle spasm □ Muscle weakness □ Shoulder pain
□ Hip pain □ Sciatica □ Bursitis □ Hand/wrist pain
□ Carpal tunnel □ Sprains/strains □ Tendonitis
□ Back pain: Low_____ Middle_____ Upper_____

CARDIOVASCULAR:

□ High blood pressure □ Low blood pressure □ Chest pain □ Fainti
□ Irregular heart beat □ Difficulty in breathing □ Blood clots □ Phleb
□ Cold hands or feet □ Swelling of hands □ Swelling of feet
□ Varicose or spider veins □ Palpitations □ Palpitations at rest
□ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

RESPIRATORY

□ Cough □ Pain with deep breath □ Difficulty in Breathing □Bronchitis
□ Easily Sweating □ Easily Winded w/ Exertion when laying down □ Asthma
□ Coughing Blood □ Phlegm □ Pneumonia □ Chest tightness

GASTROINTESTINAL:

□ Nausea □ Vomiting □ Diarrhea □ Constipation
□ Gas □ Belching □ Black stools □ Blood in stools
□ Indigestion □ Bad breath □ Rectal pain □ Hemorrhoids
□ Bleeding gums □ Food stagnation □ Bloating/edema □ Acid reflux/GERD
□ Hernia □ Excessive appetite □ Poor appetite □ IBS/Crohn's disease
□ Colitis □ Slow digestion □ Abdominal pain/cramps

GENITO-URINARY:

□ Frequent urination □ Blood in urine □ Pain upon urination
□ Urgency to urinate □ Unable to hold urine □ Kidney stones
□ Decrease in flow □ Impotency □ Sores on genitals

REPRODUCTIVE & GYNECOLOGIC:

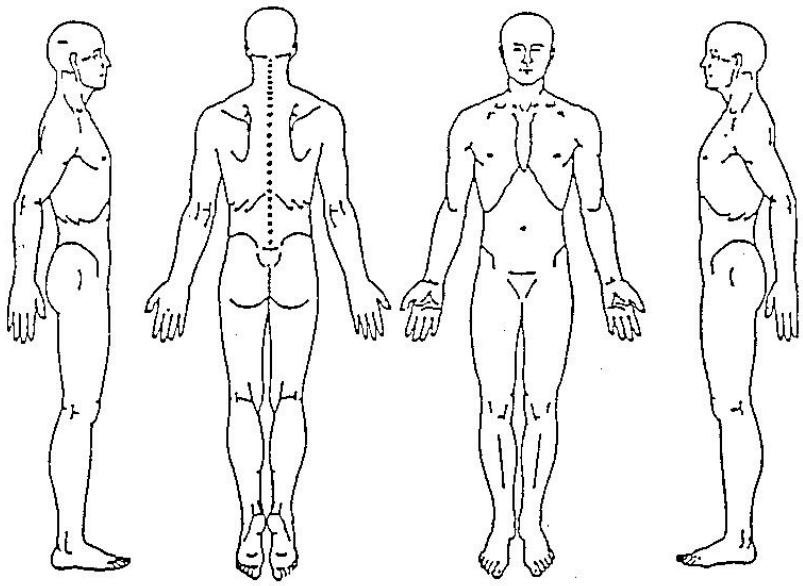
Are you pregnant? □ Yes □ No Is it possible that you are pregnant? □ Yes □ No
Number of pregnancies: _____ Live Births: _____ Miscarriages: _____
Abortions: _____ Premature births:_____
Age at first menses: _____ Time period between menses:_____
Duration of menses:_____ Last PAP: _____
□ Irregular periods □ Painful periods □ Clots □ Breast lumps
□ Vaginal sores □ Vaginal discharge □ Vaginal dryness □ Endometriosis
□ Uterine fibroids □ Polycystic Ovarian disease □ Fibrocystic breast tissue

NEUROLOGICAL & PSYCHOLOGICAL:

□ Seizures □ Dizziness □ Loss of balance □ Areas of numbness
□ Poor memory □ Concussion □ Poor coordination □ Bad temper
□ Anxiety □ Depression □ Easily susceptible to stress
□ Nervousness □ ADD/ADHD □ Manic depression

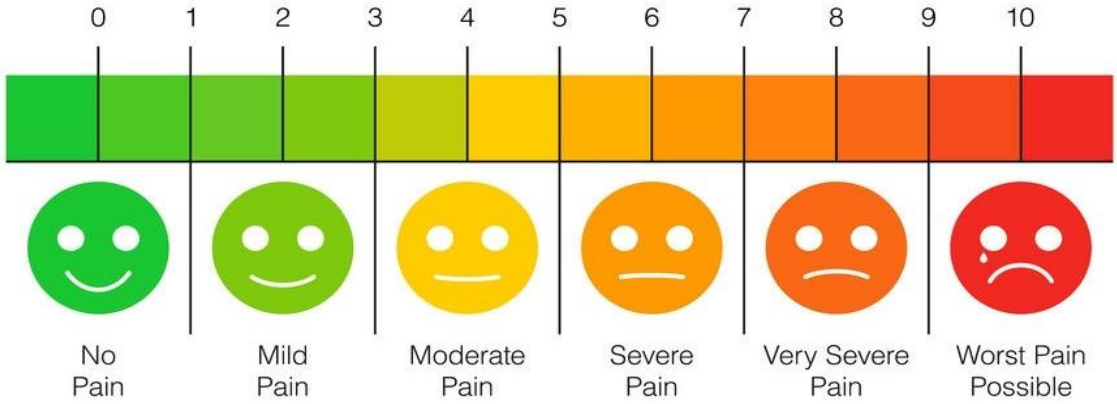
Acupuncture Intake Form

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



Please try to describe the type of the pain _____

Please circle a number that best describes the intensity of your pain:



Nature of the pain: ☐ **Dull** ☐ **Prickly** ☐ **Sharp** ☐ **Stabbing** ☐ **Burning** ☐ **Distention**

Duration: ☐ **Intermittent** ☐ **Occasional** ☐ **Continuous**

COMMENTS: *Please tell us briefly of any other problems you would like to discuss.*

_____

_____

_____

_____

_____