

Denver Community Acupuncture

Adult Patient Intake Form

All medical information is confidential. We appreciate your time, thoughtfulness and honesty in completing this overview.

I. General Information.

Name: _____ Date: _____

Address: _____ City/Zip: _____

Phone: (home) _____

(cell) _____

(work) _____

Can we leave a message? Y N

Email: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____ Hours per week: _____ Do you enjoy your work? _____

Gender: F M Married: ___ Separated: ___ Divorced: ___ Widowed: ___ Single: ___ Partnership: ___

Live with: Spouse: ___ Partner: ___ Parents: ___ Children: ___ Friends: ___ Alone: ___ Other: _____

How did you hear about us? _____

Have you ever had acupuncture before? _____

Your medical doctor's name & phone number: _____

Emergency contact name & Relationship: _____

Emergency Contact Phone Number: _____

What is your primary reason for this visit?

1)

2)

3)

What initiates your symptoms? _____

What makes them better? _____ What makes them worse? _____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

II. Initial Intake Information.

Body Temperature & Perspiration

General Body Temp: Hot Cold Where: _____

Chills? Y N Hot Flashes? Y N Night sweats? Y N Spontaneous sweating? Y N

Diet & Thirst

What do you eat: _____

What do you NOT eat: _____

Typical Food Intake: Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 Treats: _____

What percentage of your meals do you eat out? 10% 25% 50% 75% 100%

Of the meals eaten at home, what percentage are prepackaged? 10% 25% 50% 75% 100%

How does food affect you (circle all that apply)? Tired Bloating Gas Burping Pain Other: _____

How is your appetite: _____ Cravings: _____

Eat 3 meals per day? Yes No Skip meals? Yes No Taste in Mouth? Yes No

Thirst? Yes No Liquid Consumption: _____ Temp. preference: _____

Caffeine: _____ Tobacco: _____ Alcohol: _____

Marijuana use: _____ Recreational Drug Use: _____

Elimination

Urination:

Output=Input?	Yes	No
Urgency?	Yes	No
Burning?	Yes	No
Retention?	Yes	No
Dribbling?	Yes	No
Night time?	Yes	No
	# times/night:	
Blood?	Yes	No
Cloudy?	Yes	No
Color:		

Stools:

Frequency		
Formed?	Yes	No
Hard?	Yes	No
Loose?	Yes	No
Complete?	Yes	No
Constipation?	Yes	No
Diarrhea?	Yes	No
Alternating?	Yes	No
Difficulty?	Yes	No
Mucus/Blood?	Yes	No

Sleep

Hours/Night: _____ Time to Bed: _____ Time to Wake: _____ Rested upon waking? _____

Trouble falling asleep? _____ Waking at night/what time? _____ Trouble going back to sleep? _____

Dreams? _____ Worries/Thoughts? _____ Heart Palpitations? _____

Energy & Exercise

Type of Exercise? _____ How Often? _____ Energy Level? _____

Best Time of Day? _____ Worst Time of Day? _____

Emotions

At This Time: _____

Emotional History: _____

Mood Swings? _____ Anxiety? _____ Depression? _____ Irritability? _____

History of Abuse? _____ Attempted Suicide? _____ Stress Level? _____

Is your home a safe place (physically & emotionally)? Y N

Please explain:

Have you ever been touched in a way that made you uncomfortable or was harmful to you without your permission? Y N

Lifestyle

Watch TV? Y N If so, how many hours per day: _____

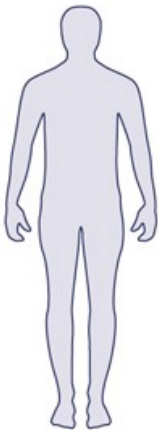
Read? Y N If so, how many hours per day: _____

Computer? Y N If so, how many hours per day: _____

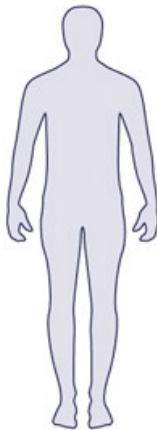
Do you have a religious or spiritual practice? Y N

Pain

****Please mark the location(s) of your pain on the diagram below****



FRONT



BACK

Location of Pain: _____

Better or Worse with:

Pressure _____

Heat _____

Cold _____

Movement _____

Rest _____

Pain Quality: _____

Fixed: _____

Radiation: _____

Body System Review

Head:

Headaches/Location? _____ How often? _____ Type of pain? _____
Dizziness? Yes No Numbness/Tingling? Yes No Fainting? Yes No
Seizure? Yes No Memory Loss? Yes No

Eyes:

Red? Yes No Itchy? Yes No Watery? Yes No Blurry? Yes No
Floaters? Yes No Decreased Night Vision? Yes No Glasses? Yes No

Ears:

ringing? Yes No Pitch: _____ Hearing Loss? Yes No Other: _____

Teeth/Gums:

Bleeding? Yes No # of Cavities: _____ Loose Teeth? _____ Other: _____

Other:

Neck/Shoulder Tension? Yes No Joint Pain: _____
Low Back Pain? Yes No Shortness of Breath? Yes No Asthma? Yes No
Allergies: _____

Are you sexually active? Y N

Birth Control? Y N Type of birth control: _____

Sexual Orientation: Heterosexual Bisexual Homosexual

Any events in your sexual history or development that you would like to share:

Female

Pregnant? Yes No Date of Last period: _____ Length of Cycle: _____

Days Bleeding: _____ Menstrual Pain? Yes No Clots? Yes No

Flow: _____ Color: _____ Age of onset? _____

PMS? Yes No Irritability? Yes No Mood Swings? Yes No Cravings? Yes No

Fatigue? Yes No Breast Tenderness? Yes No Vaginal Discharge? Yes No

Yeast Infections? _____ Birth Control: _____

Pregnancies: _____ # Births: _____ # Miscarriages: _____

Menopause: Age at Onset: _____ Hot Flashes? Yes No Night Sweats? Yes No

Male

Prostate Health: _____

Sexual Dysfunction: _____

Hernias: Y N Testicular Masses: Y N Testicular Pain: Y N

III. Health History Questionnaire.

Family History

Father: Living Age: _____ Health Status: _____
 Deceased Age at death: _____ Cause: _____

Mother: Living Age: _____ Health Status: _____
 Deceased Age at death: _____ Cause: _____

Brother(s): Health Status: _____

Sister(s): Health Status: _____

Children: Boy(s) # _____ Girl(s) # _____ Health Status: _____

Check illnesses that have occurred in any of your blood relatives:

Alcoholism Bleed easily Diabetes Heart Disease Kidney disease Obesity
 Allergy Cancer Epilepsy High blood pressure Mental illness Stroke
 Other: _____

Personal History

Check any illnesses or conditions you currently have or have had in the past:

AIDS/HIV Bleed easily Heart Disease Multiple sclerosis Shingles
 Alcoholism Cancer Hepatitis Night sweats Stroke
 Allergies Chicken Pox High blood pressure Pertussis/whooping cough Thyroid disorder
 Anemia Diabetes Jaundice Pneumonia Tuberculosis
 Antibiotic Use Epilepsy Kidney disease Polio Ulcers
 Asthma Glaucoma Mental disorder Rheumatic fever Vascular disease
 Other: _____

Do you have a PACEMAKER? Yes No

List any surgeries, serious illnesses, broken bones, hospitalizations, etc.: _____

Allergies: Are you allergic or hypersensitive to any:

Drugs? _____
 Foods? _____
 Alcohol? _____

Check the immunizations you have had:

Chicken pox Influenza
 Diphtheria/Pertussis/Tetanus Measles/Mumps/Rubella
 Hepatitis B Tetanus only
 Other: _____

List the Date and Results of last medical tests below:

DATE	TEST	RESULT	DATE	TEST	RESULT
	Cholesterol			Pap Smear	
	Hepatitis			Physical	
	HIV Test			PSA (prostate)	
	Mammography			Stool	
	Other			Other	

Current Medications (list ALL you are taking): _____

Currents Herbs/Vitamins/Supplements (list ALL you are taking): _____

Is there anything else you would like to share with us?

Patient Signature: _____ Date: _____