Living Chi

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name	Sex F M	Date	
Date of Birth	Age	Occupation	
Main phone #	Other phone #		
Email address	Allow email contact Yes No		
Emergency contact	Marital status	# of children	
Address: Street	City	State	Zip
Family Physician	Chiropractor		
Do you have health Insurance? Yes No If yes, name of insurance company			
Does your insurance cover acupuncture? Yes No	Have you ever been treated by acupuncture before? Yes No		
How did you find out about our clinic? *Friends/Relatives(name)* ______________________________ *Direct mail* *Location or walk by* *Website* *Referred by* ______________________________ *Yellow Pages* *Periodicals* *Other (please specify)*			

Main problem(s): ______________________________

What diagnosis, if any, have you received for this problem? ______________________________

When did this problem begin? ________________ What are the causes of this problem? ______________________________

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? ______________________________

What kind of treatment have you tried? ______________________________

What makes condition worse? ____________________________What makes condition better?______________________________

Is there anybody in your family with the same/similar problems? ___________ Remarks and additional information:

____

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: ______________________________**Hospitalization:** ______________________________

Significant trauma: (auto accidents, sports injuries, etc) ______________________________

Allergies: (drugs, chemicals, foods, environmental): ______________________________

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression			Anxiety		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

____

____

Occupation : _______________________________ Do you usually work indoors outdoors?

Occupational stress (chemical, physical, psychological, etc): ____

Personal Height___________ Weight now_____________ Weight one year ago__________________

Weight maximum ______________@Year _____________

Habits Do you smoke ? Yes No What? ______________ How many per day? __________ Since when? _________________

Please describe any use of drugs for non-medical purposes: ____

Do you exercise regularly Yes No Please describe your exercise program: ____

How many hours do you sleep in general? ___________ What time do you usually go to bed? ______________________________

Do you take medication to help you sleep? Yes No If Yes, What? ____

Do you wake in the night? Yes No Reason: ______________________

Diet How much coffee do you drink? _______cups/day Colas ________number/day Tea _______ cups/day

What kind of alcoholic beverages do you usually drink, if any? ____________ Average number of drinks/week? _______________

How much water do you drink per day? _______

Are you a vegetarian? Yes No Yes, but not so strict Do you eat a lot of spicy food? Yes No

Remarks and additional information (e.g. diet) ____

Please describe your average daily diet (Please be as specific as possible):

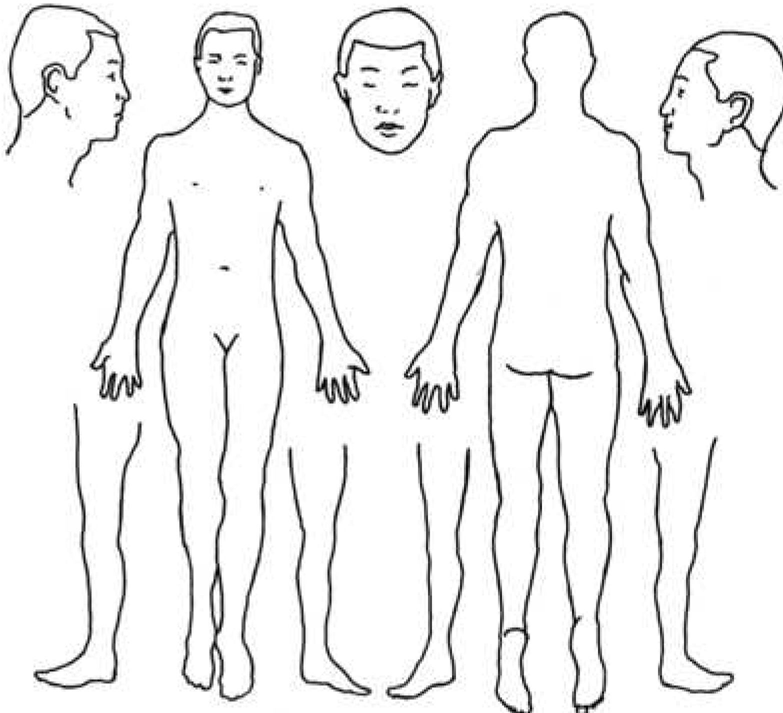
Morning ____

Afternoon ____

Evening ____

Snacks ____

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General Poor appetite Poor sleep Fatigue Fevers Chills Night sweats Sweat easily Tremors Cravings

Change in appetite Poor balance Bleed or bruise easily Localized weakness Weight loss Weight gain

Peculiar tastes Desire hot food Desire cold food Strong thirst (cold or hot drinks)

Sudden energy drop (What time of day) _________ Favorite time of year ___________ Worst time of year _________

Skin & hair Rashes Ulcerations Hives Itching Eczema Pimples Acne Dandruff Dry skin Recent moles

Loss of hair Purpura Change in hair or skin texture Other?

Musculoskeletal Joint disorders Muscle weakness Pain/soreness in the muscles Tremors Cold hands/feet

Difficulty walking Swelling of hands/feet Spinal curvature Back pain Hernia Numbness Tingling Paralysis

Joint Sprain Pain Where? _______________________ Tightness Where?_______________________________

Head, eyes, ears, nose, and throat Dizziness Concussions Migraines Glasses/lens Eye strain Eye pain

Color blindness Night blindness Poor vision Cataracts Blurry vision Ringing in ears Poor hearing

Spots in front of eyes Sinus problems Nose bleeding Sore throat Teeth problems Difficulty swallowing

Cardiovascular High blood pressure Low blood pressure Chest pain Palpitation Fainting Phlebitis

Irregular heartbeat Rapid heartbeat Varicose veins Other?

Respiratory Cough Coughing blood Wheezing Difficulty breathing Bronchitis Pneumonia Chest pain

Production of phlegm – What color? ______

Gastrointestinal Nausea Vomiting Diarrhea Constipation Gas Belching Black stools Blood in stools Indigestion

Bad breath Rectal pain Hemorrhoids Abdominal pain/cramps Gallbladder problems Parasites Chronic laxative use

Bowel movements: Frequency _______ Color ______ Odor ______ Texture/ Form _______________

Neuro-psychological Loss of balance Lack of coordination Concussion Depression Anxiety Stress Bad temper

Genito-urinary Painful urination Frequent urination Blood in urine Urgency to urinate Kidney stones

Unable to hold urine Dribbling Pause of flow Frequent urinary tract infection Genital pain Genital itching

Genital rashes STD Other?

Female Frequent vaginal infections Pelvic infection Endometriosis Vaginal/genital discharge Fibroids Ovarian cysts

Irregular periods Clots Pain/cramps prior/during periods Breast tenderness Breast Lumps Fertility Problems

Hot flashes Moodiness related to periods

______ Number of pregnancies ______ Number of births ______ Miscarriages ______ Abortions ______ Premature births

______ C-section ______ Difficult delivery

First date of last period ________________ Age of first period ______ Duration of periods ______days, cycle ____ days

Do you practice birth control ? Yes No. If yes, what type and for how long? ____

If you're on birth control pills, what are you taking and for how long? ____

Male Prostate problems Discharge Erectile dysfunction Ejaculation problems Frequent seminal emission

Fertility problems Painful/swollen testicles Other

I have completed this form correctly to the best of my knowledge.

____

Signature: Adult Patient Parent or Guardian Spouse Date