PENINSULA NATURAL HEALTH CENTER

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CONFIDENTIAL ACUPUNCTURE INTAKE

NAME (last, first, m.) _____ AGE _____ DATE OF BIRTH ___/___/___

☐ male ☐ female EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

( ) HOME/CELL PHONE-1 _____ ( ) ALTERNATE PHONE-2 _____ SOCIAL SECURITY NUMBER _____

EMAIL ADDRESS _____ REFERRED BY _____ DATE OF REFERRAL ___/___/___

PHYSICIAN _____ Permission to consult with your physician: ☐ yes ☐ no

INSURANCE COMPANY (primary) _____ POLICY NUMBER _____

INSURANCE COMPANY (secondary) _____ POLICY NUMBER _____

NAME OF INSURED _____ INSURED's SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EFFECTIVE DATE OF INSURANCE _____

( ) EMERGENCY CONTACT NAME _____ HOME PHONE _____ RELATIONSHIP TO PATIENT _____

PLEASE CHECK THE APPROPRIATE BOX: ☐ single ☐ married ☐ partnered ☐ divorced ☐ widowed ☐ separated

CHIEF COMPLAINT: _____

WHEN/HOW DID THIS START? _____

LIST ANY DOCTORS YOU HAVE SEEN FOR THIS CONDITION:

1. _____ 3. _____
2. _____ 4. _____

RECOMMENDATIONS: _____

TREATMENTS RECEIVED: _____

ARE SYMPTOMS ☐ better ☐ worse ☐ unchanged WHAT MAKES SYMPTOMS WORSE? _____ WHAT MAKES SYMPTOMS BETTER? _____

SYMPTOMS EXPERIENCED WHAT PERCENTAGE OF TIME DURING A DAY? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% ☐ other _____

LIST PREVIOUS ACCIDENTS OR INJURIES (auto, work, falls, etc.) INCLUDING DATES: _____

LIST PREVIOUS SURGERIES INCLUDING DATES: _____

MEDICATIONS: (please list all supplements, herbs, prescriptions and non-prescription drugs)

NAME OF MEDICATION | TAKEN HOW OFTEN? | WHEN DID YOU START/STOP MEDICATION

HISTORY OF ANTIBIOTIC USE ☐ yes ☐ no PLEASE DESCRIBE _____

HABITS:

	NEVER	RARELY	OCCASIONALLY	
Coffee:				Weekly/Daily Amount: _____
Black Tea:				Weekly/Daily Amount: _____
Tobacco:				Weekly/Daily Amount: _____
Alcohol:				Weekly/Daily Amount: _____
Laxatives:				Weekly/Daily Amount: _____
Aspirin/NSAIDS:				Weekly/Daily Amount: _____
Soda:				Weekly/Daily Amount: _____
Other:				Weekly/Daily Amount: _____

EXERCISE (please describe type/amount): _____

STRESS MANAGEMENT TOOLS: _____

CURRENT HEALTH CONDITION (please circle symptoms which have occurred in the past year)

ENERGY, IMMUNITY & METABOLISM

Fatigue · Energy drops · General weakness · Catch colds easily · Slow wound healing · Chronic infections · Allergies · Sweat easily · Day/night sweats · Feeling hot/flushed · Fever/chills · Recent weight gain/loss

HEAD, EYES, EARS, NOSE & THROAT

Headaches, migraines · Dizziness/vertigo · Vision changes/blurriness · Photosensitivity · Eye strain/pain/floaters · Ear ringing/earaches · Sinus problems/snoring · Nasal congestion · Nosebleeds · Sore throat/swollen glands · Hoarseness/loss of voice · Teeth grinding

RESPIRATORY & CARDIOVASCULAR

Asthma/wheezing · Difficulty breathing · Phlegm · Pneumonia · Cough · Chest tightness/pain · Cold hands or feet · Bronchitis · Palpitations · High/low blood pressure · High cholesterol · Blood clots · Varicose/spider veins · Fainting · Fluid retention/edema · History heart attack/stroke

GASTROINTESTINAL

Low/excessive appetite · Difficulty chewing/swallowing · Bad breath · Nausea/Vomiting · Heartburn/acid reflux/ulcers · Strong thirst · Belching/hiccups · Gallbladder stones · Dental/gum problems · Abdominal pain/cramps · Intestinal gas/bloating · Food/drug allergies? _____ · Diarrhea/loose stools · Constipation · Hemorrhoids/rectal pain

BOWEL MOVEMENTS

FREQUENCY _____ · Blood/mucous in stool · incomplete feeling/pain/urgency · undigested food

CONSISTENCY (circle all that apply) well-formed dry hard pellets loose soft sticky alternating

COLOR (circle all that apply) brown white/chalky green yellow orange

GENITOURINARY

Pain/urgency/burning · Nighttime urination · Blood in urine · Frequent urination · Profuse/decreased urination · Urinary tract infections · Kidney stones · Urinary retention · Bed wetting · Change in sex drive · Incontinence/dribbling · Herpes/STDs/genital sores

SKIN, HAIR & NAILS

Dry skin/scalp/dandruff · Easy bruising · Itching/eczema/psoriasis · Weak/brittle/ridged nails · Rashes/hives · Scars/moles · Acne/sores · Hair loss/thinning

NEUROLOGICAL & MUSCULOSKELETAL

Muscle weakness · Seizures/epilepsy · Lack of coordination/balance · Poor concentration/memory · Muscle spasms/tics/tremors · Slurred speech · Numb/tingling/paralysis · History of concussion/TBI

Pain: YES NO Describe _____

SLEEP

Difficulty falling/staying asleep · Tired upon waking · Vivid dreams · Restlessness · Nightmares/night terrors · Avg. hours of sleep: _____ · Sleep talking/walking · Typical bedtime: _____

EMOTIONS

Mood swings · Seasonal affective disorder · Mania/elevated mood · Nervous/anxiety/panic attacks · Sadness/tearfulness · Describe your level of happiness: _____ · Frequent worrying/fear · Irritability/anger/frustration · Depression · Obssesive/compulsive

MEN ONLY

Prostate disease · Hernia · Poor sperm motility · Testicular pain/swelling · Impotence · Irregular morphology · Low/excessive sex drive · Difficulty reaching orgasm · Low sperm count · Premature ejaculation · Nocturnal emissions · Other: _____

WOMEN ONLY

Hot flashes/flushing · Abnormal vaginal discharge/odor · Infertility · Facial hair growth · Nipple discharge · Spotting between periods · Fibroids/cysts/PCOS · Breast tenderness/lumps · Difficulty reaching orgasm · Endometriosis · Vaginal dryness · Pain during intercourse

First day of last menstrual period: _____ Duration of menstrual cycle (ex: 28 days): _____ Are cycles regular? YES NO

Date of last PAP/pelvic exam: _____ Any abnormal results? _____ Age of 1st period: _____ PMS symptoms: _____

Birth control? YES NO type: _____ **Is there any possibility that you are currently pregnant?** YES NO

Trying to get pregnant? YES NO # of pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Have you experienced menopause? YES NO If so, when? _____ Please describe menopausal symptoms: _____

By signing below, I indicate that the information above is complete and accurate to the best of my knowledge at this time.

SIGNATURE OF PATIENT _____ DATE _____