Initial Intake and Medical History (required)

Please describe what brings you in today.

How did this condition begin? What makes it better or worse?

Have you seen any other health care providers for this issue? If yes, please list treatments

Do you take any medications or supplements? Please list:

Do you have any allergies to food or medication? Anyone in your household have severe allergies?

Surgical history (include dates)

Medical History (please check all that apply)

- migraine headaches
- epilepsy/seizures
- high blood pressure
- depression/anxiety
- asthma
- autoimmune disease
- stroke
- diabetes
- HIV/AIDS

- cancer/tumor
- thyroid disease
- heart attack
- hepatitis A, B, or C
- high cholesterol
- irritable bowel syndrome or Crohns
- rheumatoid arthritis
- TMJ

Sleep

- Hard to fall asleep
- Insomnia with indigestion
- Excessive thoughts/worry
- easy wakening at night, hard to fall back asleep
- restless sleep
- restless legs
- excessive or disrupting dreams
- feel hot or sweaty at night
- wake too early

Are you pregnant now?

- Yes
- No
- Unsure

If pregnant how many weeks? (Please fill out pregnancy form.)

Number of Pregnancies

Number of live births. Twins count as two.

Miscarriages or Loss

How far along were you when the miscarriage occurred? How long ago did it occur?

What age did your menses begin? Have you began menopause? If so what age did that begin?

Menses (please check all that apply)

- cramping
- vaginal discharge
- premenstrual changes
- strong vaginal odor
- breast tenderness
- fibrocystic breasts
- low back pain
- onset of menopause
- premenstrual irritibility
- menstrual clots
- heavy menstrual flow
- light menstrual flow
- bleeding between periods
- I am menstruating today

Women's Health

- Frequent urinary infections
- Frequent vaginal infections
- Pain/itching in gentials
- Lesions/discharge
- Pelvic inflammatory disease
- Abnormal bleeding

- Menopausal symptoms
- Hot flashes
- Fibroids
- Pcos
- pain with intercourse
- infertility (please fill out fertility form)

General Health (please check all that apply)

- poor appetite
- excessive appetite
- general fatigue/low energy
- night sweats
- easily sweating
- chills
- poor coordination
- bleed or bruise easily
- catch colds easily
- strong thirst
- dry mouth/throat
- fever/hot body temp
- cold hands/feet

Respiratory

- Asthma
- Diffucilty Breathing
- Bronchitis
- Frequent Colds
- Pneumonia
- Cough
- Coughing Blood
- Production of phlegm
- Dry cough

Skin and Hair

- Rashes
- Hives
- Itching
- Eczema
- Pimples/Acne
- Dryness
- Tumors/Lumps
- Hair Loss
- Ear Infections

Muscoloskeletal

- Low back pain
- All over back pain
- Muscle spasms, twitching
- Sore, cold weak knees
- Joint Pain
- Shoulder pain
- Elbow/arm pain
- Wrist/hand pain
- Hip/upper leg pain
- Ankle/foot pain

Nose, Throat & Mouth

- Nose Bleeds
- Sinus Infections
- Hay fever/ allergies
- Frequent sore throats
- Grinding Teeth
- Difficulty Swallowing
- Dry Mouth/ throat
- Mouth Sores
- Bad breath

Neurological

- Seizures/Tremors
- Numbness of Limbs
- Paralysis
- Mental illness

Head & Neck

- Dizziness
- Fainting
- Neck stiffness
- Enlarged lymph
- Headaches
- Ringing in ears
- Hearing loss
- Frequent ear aches

Infection Screening

- HIV
- TB
- Hepatitis
- Gonorrhea
- Chlamydia
- Syphilis

Eyes

- Blurred vision
- Visual changes
- Poor night vision
- Seeing floaters or spots
- Eye inflammation
- Vision loss

Genito-Urinary

- kidney stones

- pain with urination
- frequent urination
- blood in urine
- poor bladder conrol
- changes in urine flow/color
- waking at night to urinate
- cloudy urine
- dark yellow urine
- itching in genital area
- bladder or urinary tract infections

Gastrointestinal

- Nausea
- Vomitting
- Diarrhea
- Belching
- Blood in stools/black
- Loose stool
- Hemorrhoids
- Constipation
- Pain or cramps
- Indigestion
- Gallbladder disorder
- Heartburn/acid reflux
- Gas & bloating

Cardiovascular

- High BP
- Low BP
- Blood clots
- Palpitations
- Chest pain
- Irregular heartbeat

- Swelling of hands & feet

Psychological

- Depression
- Anxiety/stress
- Irritability
- Worry
- Weepiness
- Inability to express emotions
- Anger
- Fear
- Mental illness

Do you have a mental illness you would like us to know about?

Do you feel suicidal currently? Have you attempted or considered suicide in the past?

Are you currently in therapy or have you been in the past?

Have you experienced any past traumas you would like us to know about?

Do you have any addiction issues you would like us to know about?

Please check all that apply

- I have a pacemaker
- I have a seizure disorder

- [ ] I faint easily or have fainted or become nauseated while receiving a treatment with needles
- [ ] I have cochlear implants
- [ ] I have a bleeding disorder
- [ ] I am on a blood thinner or medication that requires INR testing
- [ ] I am diabetic
- [ ] I have a compromised immune system
- [ ] I have eaten something in the last 4 hours (if not please discuss with your provider)
- [ ] I have had acupuncture before today
- [ ] I am menstruating today

Do you have areas of decreased sensation? Please describe where.

Choose One Copy *

Check One Copy *