JUBILATION ACUPUNCTURE
Acupuncture Intake Form

Chinese Medical Diagnosis requires complete and honest answers to questions pertaining to both the body and the spiritual/emotional state. Thank you for taking the time to fill out this form completely.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Best phone # to contact you at:_____ other phone #_____

e-mail address_____

In case of emergency contact_____

Address (if different from above)_____

Phone_____ Relationship_____

Please describe the reason for your visit today (Chief Complaint)_____

_____

Is it getting better, worse, or staying the same?_____

_____

Are you, or have you been, treated for this problem with any other health professionals?

_____

Has it been effective?_____

What was your diagnosis?_____

Are you taking any medication or herbal supplements? If so, which ones? (Add dosage if known)

_____

MEDICAL HISTORY

Please circle any current health issue. For those diseases which are part of your health history, please note the year of the occurrence.

Allergies
Anemia
Appendicitis
Arteriosclerosis
Asthma
Bleeding Disorder
Blood Pressure (Low or High)
Cancer
Chicken Pox
Diabetes
Digestive Disorders
Emotional Difficulties
Other_____
Emphysema
_____

Epilepsy
Fatigue
Gout
Heart Disease
Hepatitis (A, B,C)
Hypoglycemia
Injuries
Insomnia
Intestinal Parasites

Multiple Sclerosis
Mumps
Pacemaker

Weight Loss or Gain

Polio
Scarlet Fever
Stroke
Surgery (List):
_____
_____
_____
Thyroid Disorder
Trauma (falls, accidents)

Tuberculosis
Ulcers

Do any of your family members suffer from: (Please list relationship to you)

Alcoholism
Allergies (list)
_____
_____

Arteriosclerosis
Asthma
Cancer
Diabetes

Heart Disease
High Blood Pressure
Seizures
Stroke

Which of the following are part of your lifestyle? How frequently do you engage in it?

Alcohol
Coffee

Nicotine
Recreational Drug Use

Exercise
Excessive Sugar

Do you usually eat three meals a day? _____Do you follow any particular diet?_____

On the scale of 1-10, how would you rate the level of stress in your life currently?

What is the level of stress in your life in general (1-10)?

How does stress affect you? (ie, more headaches, stomach pain, etc.)

Are there any other concerns you would like to address?

_____

_____

REVIEW OF SYSTEMS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! If you're currently experiencing the symptom circle it, if you have experienced it in your past, please put a check by it.

Head and Face
Headaches
Dizziness
Memory Loss
Other

Eyes
Blurry Vision
Eyelid Twitching
Floaters
Pain

Nose
Frequent Colds
Sinus Trouble
Bleeding

Mouth
Dental Problems
Gum Problems
Teeth Grinding/TMJ
Unusual Tastes
Other

Throat
Sore Throat
Hoarseness
Difficulty Swallowing
Dryness
Other

Respiration
Difficulty Inhaling
Difficulty Exhaling
Pain
Cough
Congestion
Shortness of Breath
Other

Heart and Chest
High Blood Pressure
Low Blood Pressure
Chest Pain
Chest Tightness
Difficulty Lying Down
Other

Circulation
Easy Bruising
Easy Bleeding
Cold Limbs-Hands or Feet
Reynaud's Syndrome

Gastrointestinal
Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain
Nausea
Diarrhea/Loose Stools
Constipation
Rectal Bleeding
Colon Problems

Urination
Frequent
Difficult
Painful
Nocturnal
Bleeding
Other

Skin
Acne
Dryness
Moles that Change
Lumps
Excessive Sweating
Night Sweats
Rarely Sweat
Other

Neurological
Nervousness/Anxiety
Tremors
Numbness or Tingling
Lack of Coordination
Nerve Pain
Other

Sleep
Insomnia
Drowsiness
Excessive Dreaming
Waking Easily
Other

Pain - Please Describe
_____
_____
_____
_____

Are there any other health concerns you'd like to address?
_____
_____

WOMEN

Are you, or could you be pregnant?_____ If so, how far along?_____

Number of pregnancies_____ Births_____ Abortions_____Miscarriages_____

What form of birth control do you use?_____

Age of first menses_____ Age of menopause, if applicable_____

Do you bleed between periods?_____

Have you ever had any gynecological surgeries or any abnormal findings on any tests?__

_____

Are your periods uncomfortable or painful, either emotionally or physically?_____

Are your periods:

Short (Less than 28 days)_____Long (28+ days)_____Varied_____ Regular_____

Painful? If so, Before_____ During_____ After_____

Do you bleed heavily_____? Lightly_____? Very little?_____

Do you have clots ?_____ Early in the cycle_____ or throughout?_____

Relative to the blood that comes from a wound, is your menstrual blood: The same color_____More pale_____ Purple_____ More Red_____ More Brown_____

How many days do you bleed?_____

Do you have any of the following Pre-Menstrual Symptoms? (Emotions are not judged in Chinese Medicine, they are neither good nor bad. They are, however, important diagnostic tools. Please answer honestly.)

Irritability____ Depression_____ Crying_____ Rage_____ Nausea_____

Cravings, and if so for what?_____Breast Tenderness_____

Any other symptoms around the time of your period?_____

_____

Do you have any other gynecological concerns or complaints?

MEN

Do you experience any of the following:

Reduced Libido_____ Excessive Libido_____ Impotence_____

Urinary Frequency_____ Premature Ejaculation_____ Discharge_____

Genital/ Testicular pain_____

Any other concerns?_____

I have provided correct and complete information to the best of my knowledge.

_____ _____

Patient's or Guardian's signature Date