Acupuncture and Eastern Medicine Patient Intake Form

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First Name: _____MI_____ Last Name: _____ Date: _____/_____/_____

Birth Date: _____/_____/_____ Age: _____ Height: _____ Weight: _____

Home Phone: (____) _____ Cell: (_____)_____Wk: (____)_____

Which phone number do you prefer me to use? Hm ____ Cell _____ Wk_____Messages ok? _____

Address:_____City_____State_____Zip_____

Email Address _____Gender: M___F___Binary___ Other____

Would you like to receive email updates / special offers from Teresa Jansen, L.Ac? Yes____ No _____

Married ____ Single _____ Other _____ Occupation: _____

Referred By: _____ Primary Care Physician: _____

Insurance Information

Do you want me to bill your insurance? _____ Do you owe a copay? How much? _____

Insurance Co:_____ Phone #_____

Policy Number(incl alpha prefix):_____Group #: _____

Employer: _____ Contact person (Auto): _____

Is this an auto accident claim? _____ If so, Date of Injury? _____/_____/_____

Are you the Primary Subscriber: Yes No (If no, complete below)

*Primary Policyholder Name:*_____ *DOB*_____/_____/_____

*Relationship to Patient: (parent, spouse, etc)*_____

*Phone:(_____)*_____*Employer:* _____

*Address (if different than patient):*_____

Have you ever had acupuncture? _____ If yes, when? _____

For what condition? _____

Main reason(s) for seeking acupuncture today? _____

_____

How long have you experienced symptoms? _____

Circle any other treatments you have had for this condition? Medications, massage, chiropractic, physical therapy, steroid injections, other _____

Do you have pain or tightness? No/Yes

The pain is (circle all that apply):

Sharp	Dull	Aching	Numb	Superficial Pain
Burning	Tingling	Shooting	Deep Pain	Pain worse in AM/PM
Pain worse/better with heat		Pain worse/better with cold		Pain worse/better with pressure

What number best describes your pain now?

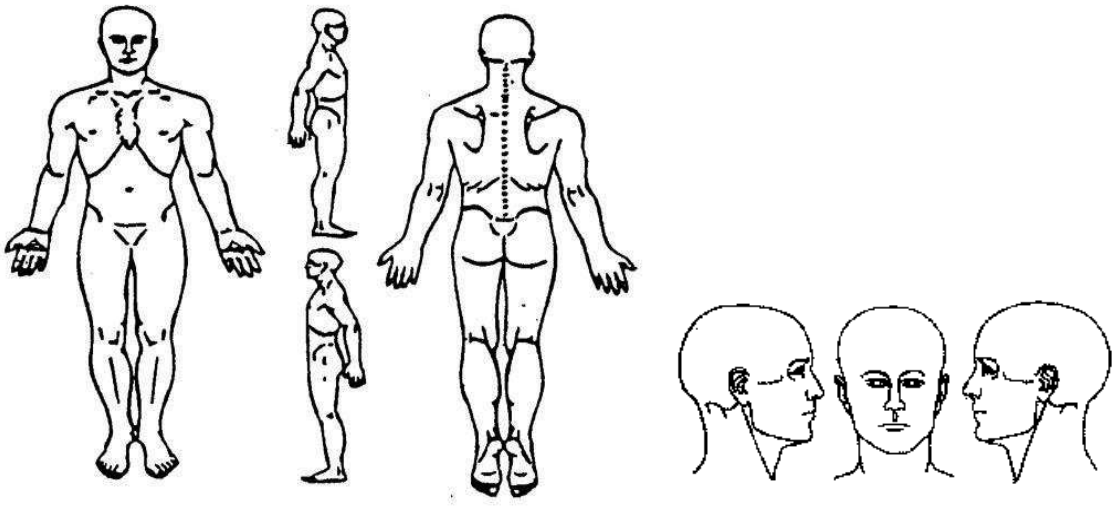
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

What makes the pain worse: _____

What makes the pain better: (circle all that apply):

Heat Cold Massage Movement Rest

Please indicate any area(s) of pain:



Medicines(you may attach med sheet):

Prescription drugs you are currently taking:	Amount:	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over-the-counter medication you are currently taking:	For what condition?
_____	_____
_____	_____

Current vitamins/supplements you are currently taking:	For what condition?
_____	_____
_____	_____
_____	_____

Please list any allergies (chemical, drug, food, and environmental):

_____

Are you allergic to (please circle): coconut, silicone, latex, lavender or nickel

Diet/Habits

Please indicate usage per day or per week:

Water _____ glasses per day

Coffee _____ cups per day/week (circle)

Tea _____ cups per day/week (circle)

Alcohol _____ day/week Type: liquor/beer/wine (circle)

Soft Drinks _____ day/week

Cigarettes _____ day/week

Sweets _____ day/week

Special Diet? No/Yes Type (vegetarian, vegan, glutan-free, etc): _____

_____

_____

Do you exercise? No/Yes How often? _____

What non-work activities do you enjoy doing (reading, TV, meditation, music, etc)? _____

_____

Do you have (circle all that apply):

Panic attacks	Depression	Anxiety	Bad temper
Nervousness	Fear attacks	Poor memory	Difficulty concentrating

How long do you normally sleep? _____ hours per night.

I have difficulties with (circle all that apply):

Falling asleep Staying asleep Dream-disturbed sleep

Waking up at about _____ am/pm and not being able to fall asleep again

Surgical History

Surgery	Date	Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check if you have had any of these conditions in the **past three months**.

General
- o Insomnia
- o Dreams/Nightmares
- o Irritability
- o Depression
- o Mood swings
- o Fatigue
- o Poor memory
- o Strongly like cold drinks
- o Strongly like hot drinks
- o Recent weight loss/gain
- o Cold hands & feet
- o Chills
- o Fever

Head & Neck
- o Headaches
- o Migraines
- o Stiff neck
- o Dizziness
- o Fainting
- o Swollen glands

Ears
- o Ringing
- o Hearing Loss
- o Infections
- o Earache
- o Hearing aids
- o Vertigo

Eyes
- o Glasses/contact lenses
- o Blurred vision
- o Poor night vision
- o Spots or floaters
- o Eye inflammation
- o Double vision
- o Glaucoma
- o Cataracts

Nose, Throat & Mouth
- o Sinus infection
- o Hay fever/allergies
- o Frequent sore throat
- o Difficulty swallowing
- o Mouth & tongue ulcers
- o Frequent colds
- o Nosebleed
- o Dry nose
- o Nasal congestion
- o Loss of voice
- o Thirst
- o Excessive phlegm
- o TMJ
- o Facial pain
- o Gum problems
- o Dry mouth

Endocrine
- o Diabetes
- o Hyperthyroidism
- o Hypothyroidism

Skin
- o Hives
- o Rashes
- o Eczema / psoriasis
- o Night sweating
- o Excess sweating
- o Dry skin
- o Easy bruising
- o Changes in moles, lumps
- o Itching

Respiratory
- o Difficulty breathing
- o Difficulty breathing when lying down
- o Wheezing
- o Asthma
- o Chronic cough
- o Wet cough
- o Dry cough
- o Coughing up phlegm
- o Coughing up blood
- o Tight chest
- o Pneumonia
- o Emphysema / COPD

Cardiovascular
- o High blood pressure
- o Low blood pressure
- o Chest pain or tightness
- o Palpitations
- o Rapid heart beat
- o Irregular heart beat
- o Poor circulation
- o Swollen ankles
- o Phlebitis
- o Anemia
- o History of heart attack
- o Pacemaker
- o High Cholesterol

Gastrointestinal
- o Nausea
- o Indigestion
- o Stomach pain
- o Diarrhea
- o Constipation
- o Poor appetite
- o Excessive hunger
- o Vomiting
- o Gas
- o Hiccups
- o Acid regurgitation
- o Bloating
- o Bad breath
- o Laxative use
- o Bloody stool
- o Mucus in stool
- o Hemorrhoids
- o Gall bladder disorder
- o IBS
- o Diverticulitis

Musculoskeletal
- o Arthritis
- o Joint pain/disorder
- o Sore muscles
- o Weak muscles
- o Difficulty walking
- o Neck/shoulder pain
- o Upper back pain
- o Lower back pain
- o Rib pain
- o Limited range of motion
- o Other (describe)

_____

Neurological
- o Seizures
- o Tremors
- o Numbness or tingling
- o Pain
- o Paralysis
- o Poor coordination
- o Other (describe)

_____

Genito-urinary
- o Pain on urination
- o Frequent urination
- o Urgent urination
- o Blood in urine
- o Unable to hold urine
- o Incomplete urination
- o Bedwetting
- o Wake to urinate
- o Increased libido
- o Decreased libido

- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles
- Infertility

Infection Screening
- HIV risks: self or partner
- TB: self or household
- Hepatitis Risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral or genital

Other Conditions
- Chronic Fatigue
- Fibromyalgia
- Raynaud's Syndrome
- Cancer
- Anemia

Other condition(s) not listed_____

_____

For Women:

Age of 1st menstrual period (menarche): _____ Age of last menstrual period (if menopausal): _____

Date of last menstrual period: _____/_____/_____

Number of days between periods: _____ Number of days of flow: _____

Color of flow (bright red, dark red, purple, etc): _____ Clots?(circle): Yes No

Average number of pads/tampons you use per day:

1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Please circle any of the following symptoms related to menses:

Discharge	Vaginal dryness	Headache / Migraine
Nausea	Constipation	Diarrhea
Swollen breasts	Mood swings	Ravenous appetite
Poor appetite	Hot flashes	Night sweats
Increased libido	Decreased libido	Insomnia

Have you been diagnosed with:

Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID Other: _____

Are you pregnant? Yes (wks?)_____ No Are you trying to get pregnant? Yes No

Number of live births _____ Number of total pregnancies _____

Date of last Gynecological Exam:_____ Date of last Mammogram: _____