Patient Intake Form

Anne Kinchen, Licensed Acupuncturist
Water Tower Plaza
25200 Chagrin Blvd #103
Beachwood, OH 44122
(216) 292-9698
clevelandacupuncture.com

Name (last, first) _____ Date _____

Address _____

City / State / Zip _____

Home phone _____ Work Phone _____

Cell Phone _____ Email _____

Occupation _____ Birth Date _____ Age_____

Emergency contact _____
(name & phone)

Referred by _____

___ Single
___ Married
___ Divorced
___ Significant Other
___ Widowed

___ Caregiver for dependent children _____

Have you ever had acupuncture? _____ If yes, when? _____ for what condition?_____ by whom?_____

Are you currently under the care of a physician? _____If so, who, and for what condition(s)?

Have you seen any other medical care provider for this condition? If so please explain diagnosis

_____

Main reason(s) for seeking acupuncture today

_____

How long have you experienced symptoms? _____

Your condition is improved by

_____

Your condition is aggravated by

_____

List all current medications, prescribed or over the counter, vitamins, herbs and other supplements

_____

Significant illnesses (please check all that apply)

___ Cancer
___ Diabetes
___ Hepatitis
___ Heart Disease
___ Stroke
___ Seizures
___ HIV / AIDS
___ Pneumonia
___ Tuberculosis
___ Multiple sclerosis
___ Other _____

___ Thyroid
___ Asthma
___ Stomach Ulcers
___ Obesity
___ Depression
___ Shingles
___ Chronic Fatigue
___ Rheumatic Fever
___ High Blood Pressure
___ STDs

Please list any surgeries you've had including dates

_____

Please list any allergies

_____

Please list any major emotional or physical traumas you've experienced

_____

Lifestyle (please check all that apply, and note frequency of use)

___ Tobacco
___ Alcohol
___ Recreational drugs
___ Caffeinated beverages

Do you exercise? _____ Please list types of activity and frequency:

_____

Nutrition

Please check if any of these apply to you:

___ Vegetarian
___ Vegan
___ Raw foods diet
___ Low fat diet
___ High protein/low carb (Atkins)

Do you eat the following foods?

___ red meat ____ X per week
___ fish _____ X per week
___ artifical sweeteners _____ X per week
___ coffee _____ X per week
___ fast food _____ X per week
___ white flour breads, pretzels, etc.
___ salads
___ cooked vegetables
___ eggs

Please check if any of the following apply to you:

___ Ice chewing
___ Extreme thirst
___ Thirst with no desire to drink

Appetite / Digestion

___ extreme appetite
___ no appetite
___ nausea
___ bulimia
___ anorexia
___ cravings
___ dieting
___ feeling of fatigue between meals/low blood sugar
___ tired after eating
___ bloating
___ gas
___ reflux
___ heartburn/ulcers
___ GERD

How many meals per day? _____ How many snacks per day? _____

Intestinal

___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use
___ Bloody stool
___ Mucous in stool
___ Anal fissures
___ Rectal prolapse
___ Other _____
___ Intestinal pain/cramping
___ Incomplete evacuation
___ IBS
___ Colitis
___ Crohn's Disease
___ Gout
___ Celiac Disease
___ Gallstones

Sleep

___ Falls asleep easily
___ Lie in bed with eyes open
___ Wake as specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams
___ Wake up not feeling rested
___ Nightmares or Frightening dreams
___ Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat

___ Dry eyes
___ Spots / flowery vision
___ Blurred vision
___ Poor vision
___ Eye strain
___ Night blindness
___ Cataracts
___ Macular degeneration
___ Bleeding gums
___ TMJ
___ Sores on tongue or mouth
___ Dry mouth

___ Excess saliva
___ Sinus problems
___ Post-nasal drip
___ Sore throat
___ Headaches
___ Swollen glands
___ Difficulty swallowing

___ Earaches
___ Tinnitus / ringing
___ Deafness
___ Nosebleed
___ Other
_____

Cardiovascular / Respiratory

___ Heart palpitations
___ Chest pain
___ Difficulty breathing
___ High cholesterol
___ Varicose veins
___ Blood clots
___ Swollen ankles
___ Heart valve abnormality
___ Shortness of breath

___ Cold hands / feet
___ Dry cough
___ Wheezing
___ Chest tightness
___ Difficult inhalation
___ Difficult exhalation
___ Productive cough
(color of phlegm?)
___ Other _____

Skin / Hair

___ Dry skin
___ Rashes / hives
___ Eczema
___ Psoriasis
___ Pimples / acne
___ Fungal infections

___ Brittle nails
___ Ridged nails
___ Hair loss
___ Dandruff
___ Other _____

Musculoskeletal

___ Spinal pain
___ Joint pain
___ Tendonitis
___ Swelling
___ Arthritis
___ Limited range of motion

___ Disc degeneration
___ Osteoporosis
___ Numbness
___ Carpal tunnel
___ Other _____

Neuropsychological

___ Anxiety
___ Irritability
___ Insomnia
___ Depression
___ Easily stressed

___ Poor memory
___ Seasonal mood disorder
___ Tics
___ Tremors
___ Death of someone close

___ Job stress
___ Recent divorce
___ Currently in therapy
___ Financial setback
___ Other _____

Emotional stress scale

1 2 3 4 5 6 7 8 9 10

no stress moderate extremely stressed

Rate your stress level regarding the following areas (1 is low, 10 is high)

Work _____
Health _____
Love _____
Money _____
Family _____
Future _____
Friends _____

Are you currently working with a therapist? yes_____ no_____

Do you suffer from: depression ____ anxiety _____ cry easily_____ irritability_____

Do you work out/exercise? yes____ no_____

If yes, how many X per week? _____

yoga _____
weight training _____
Pilates _____
running/walking _____
other_____

Genito-urinary

___ Frequent urination
___ Loss of urine when laughing or sneezing
___ Incomplete urination / retention
___ Dribbling
___ Burning urination
___ Blood in urine
___ Wake frequently to urinate
___ Kidney stones
___ Bedwetting
___ Bladder Prolapse
___ Decreased libido / sexual desire
___ Other _____

Men only

___ Enlarged prostate
___ Prostate cancer
___ Testicular cancer
___ Testicular pain or swelling
___ Erectile dysfunction
___ Impotency
___ STDs _____

Women only

Age menses began _____
Age menses ended (if applicable)_____
Date of last ob/gyn exam _____
Hysterectomy? ___ partial ___ full

___ Hormone replacement therapy
___ Live births
___ Miscarriage
___ Abortions
___ Infertility
___ Birth control pills
___ Breast cancer
___ Ovarian cysts
___ Fibroids
___ Endometriosis
___ Candida / yeast
___ Vaginal discharge
___ Vaginal odor
___ Vaginal sores
___ Herpes
___ Human Papilloma Virus positive
___ Uterine prolapse
___ STD history (chlamydia, PID, etc)
___ Fibrocystic breast

Period lasts _____ days Usual number of days in cycle _____

Headaches ___ before menstrual cycle ___ during cycle ___ after cycle

___ Pain at ovulation
___ Cramps / low back pain
___ Acne associated with period
___ Constipation associated with period
___ Diarrhea associated with period
___ Depression or irritability with period
___ Bleeding outside of normal menstrual cycle
___ No period / skipped cycles
___ Irregular cycle

Menstrual flow

___ Clotting
___ Brownish
___ Watery, thin and bright red
___ Normal red
___ Flooding and trickling
___ Stop and start flow