

## Patient Intake Form

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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  Significant Other  
 Married  Widowed  
 Divorced

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

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Your condition is aggravated by

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

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Significant illnesses (please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Stomach Ulcers      |
| <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Obesity             |
| <input type="checkbox"/> Stroke             | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Shingles            |
| <input type="checkbox"/> HIV / AIDS         | <input type="checkbox"/> Chronic Fatigue     |
| <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> STDs                |
| <input type="checkbox"/> Other _____        |  |

Please list any surgeries you've had including dates

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Please list any allergies

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

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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:

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### 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
- artificial 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

- |   |   |
|---|---|
| <input type="checkbox"/> extreme appetite                                 | <input type="checkbox"/> tired after eating |
| <input type="checkbox"/> no appetite                                      | <input type="checkbox"/> bloating           |
| <input type="checkbox"/> nausea   | <input type="checkbox"/> gas                |
| <input type="checkbox"/> bulimia  | <input type="checkbox"/> reflux             |
| <input type="checkbox"/> anorexia   | <input type="checkbox"/> heartburn/ulcers   |
| <input type="checkbox"/> cravings   | <input type="checkbox"/> GERD               |
| <input type="checkbox"/> dieting  |   |
| <input type="checkbox"/> feeling of fatigue between meals/low blood sugar |   |

How many meals per day? \_\_\_\_\_ How many snacks per day? \_\_\_\_\_

## Intestinal

- |   |   |
|---|---|
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Intestinal pain/cramping |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Incomplete evacuation    |
| <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> IBS                      |
| <input type="checkbox"/> Anal itching / burning | <input type="checkbox"/> Colitis                  |
| <input type="checkbox"/> Laxative use           | <input type="checkbox"/> Crohn's Disease          |
| <input type="checkbox"/> Bloody stool           | <input type="checkbox"/> Gout                     |
| <input type="checkbox"/> Mucous in stool        | <input type="checkbox"/> Celiac Disease           |
| <input type="checkbox"/> Anal fissures          | <input type="checkbox"/> Gallstones               |
| <input type="checkbox"/> Rectal prolapse        |   |
| <input type="checkbox"/> Other _____            |   |

## Sleep

- |   |   |
|---|---|
| <input type="checkbox"/> Falls asleep easily        | <input type="checkbox"/> Wake up not feeling rested               |
| <input type="checkbox"/> Lie in bed with eyes open  | <input type="checkbox"/> Nightmares or Frightening dreams         |
| <input type="checkbox"/> Wake as specific times     | <input type="checkbox"/> Need drugs or supplements to fall asleep |
| <input type="checkbox"/> Wake repeatedly            |   |
| <input type="checkbox"/> Wake frequently to urinate |   |
| <input type="checkbox"/> Vivid or Lucid Dreams      |   |

## Head, Eyes, Ears, Nose and Throat

- |   |   |
|---|---|
| <input type="checkbox"/> Dry eyes               | <input type="checkbox"/> Cataracts                |
| <input type="checkbox"/> Spots / flowery vision | <input type="checkbox"/> Macular degeneration     |
| <input type="checkbox"/> Blurred vision         | <input type="checkbox"/> Bleeding gums            |
| <input type="checkbox"/> Poor vision            | <input type="checkbox"/> TMJ                      |
| <input type="checkbox"/> Eye strain             | <input type="checkbox"/> Sores on tongue or mouth |
| <input type="checkbox"/> Night blindness        | <input type="checkbox"/> 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

- |  |   |
|--|---|
| <input type="checkbox"/> Enlarged prostate           | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Prostate cancer             | <input type="checkbox"/> Impotency            |
| <input type="checkbox"/> Testicular cancer           | <input type="checkbox"/> STDs _____           |
| <input type="checkbox"/> Testicular pain or swelling |   |

Women only

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

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

Period lasts \_\_\_\_\_ days      Usual number of days in cycle \_\_\_\_\_

Headaches  before menstrual cycle  during cycle  after cycle

- |  |   |
|--|---|
| <input type="checkbox"/> Pain at ovulation                   | <input type="checkbox"/> Depression or irritability with period     |
| <input type="checkbox"/> Cramps / low back pain              | <input type="checkbox"/> Bleeding outside of normal menstrual cycle |
| <input type="checkbox"/> Acne associated with period         | <input type="checkbox"/> No period / skipped cycles                 |
| <input type="checkbox"/> Constipation associated with period | <input type="checkbox"/> Irregular cycle                            |
| <input type="checkbox"/> Diarrhea associated with period     |   |

Menstrual flow

- |  |   |
|--|---|
| <input type="checkbox"/> Clotting                    | <input type="checkbox"/> Normal red             |
| <input type="checkbox"/> Brownish                    | <input type="checkbox"/> Flooding and trickling |
| <input type="checkbox"/> Watery, thin and bright red | <input type="checkbox"/> Stop and start flow    |