

Murrysville Acupuncture Intake Form

Personal Information (all information will remain confidential)

Patient Name: _____

Age: _____ Birth Date: ____/____/____ Gender: M F

Address: _____ City: _____

State: _____ Zip: _____

Telephone (Day): _____ (Night): _____ (Cell) _____
please circle the number you would like us to use to contact you

E Mail Address: _____

Occupation: _____ Hours per week: _____

How did you hear about us? _____

Who is your primary health care provider/MD? _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Is this your first experience with Acupuncture? Y N

Main Complaint

Please identify your major health concerns

1. _____

How long have you had this problem? _____

2. _____

How long have you had this problem? _____

3. _____

How long have you had this problem? _____

What makes your symptoms better? _____

What makes them worse? _____

Have you been given a diagnosis for these problems? If so please explain: _____

What other treatments have you tried and what were the outcomes? _____

Personal Medical History (Please include your childhood history and approximate dates)

Illnesses : _____

Surgeries: _____

Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.) _____

Do have a history of current or past infectious disease? Please describe: _____

Medicines (please list all medications, herbs, vitamins and over the counter drugs)

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Allergies/Sensitivities (including food, pets, environmental etc...)

Family Medical History: (please check any major illness your parents or siblings have had)

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Nervous Illness | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood pressure | |

Daily Life:

What is your stress level on a scale of 1-10? _____

In what part of your body do you hold stress?

What do you do to relax?

Do you exercise on a regular basis? Y N

What type of exercise? _____ How often? _____

Please circle usage per day or per week:

Water _____ glasses per day

Coffee _____ cups per day/week

Tea _____ cups per day/week

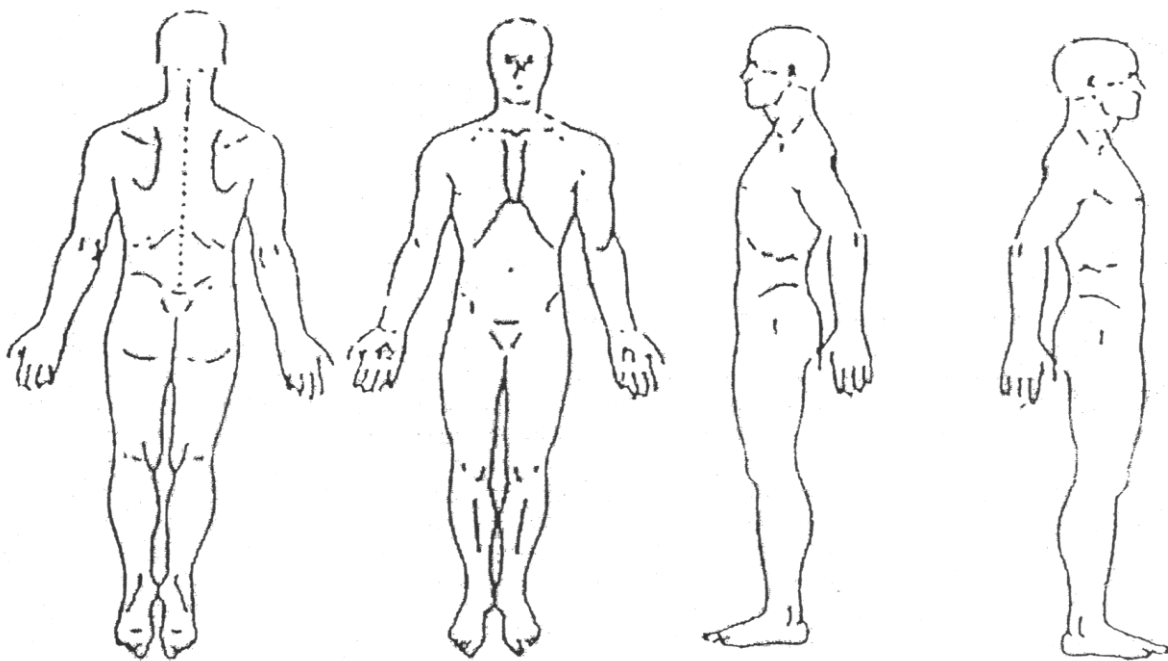
Soft drinks _____ per day/week

Alcohol _____ per day/week

Type: liquor – beer – wine (circle all that apply)

Cigarettes _____ packs per day/week

Recreational Drugs _____ per day/week



Please clearly mark any areas of pain.

Is the pain:

- | | | |
|-----------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Aching | |

Does the following lessen the pain?

- | | | |
|-----------------------------------|-------------------------------|---------------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Heat | |

Do the following worsen the pain?

- | | |
|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Other: _____ |

Please check or circle all that apply

General Overview

- High blood pressure
- Low blood pressure
- High cholesterol
- Hyperthyroid
- Hypothyroid
- History of blood clots
- Migraines
- Pace Maker
- Metal implants
If so where _____

General Headaches

- Frontal
- Sides of head
- Top of head
- Back of head
- Whole head
- Sinus

Is the pain

- Sharp
- Dull
- Heavy
- Comes and goes

How many hours of sleep do you normally get? _____ Do you feel rested after waking? Y N

Do You:

- Awake Easily
- Have Difficulty Falling Asleep
- Have Restless Sleep
- Have Vivid Dreams
- Disturbing Dreams
- Nightmares
- Sleep Too Much
- Other

Overall Temperature (KI, HT)

- | | | |
|--|--|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Afternoon flushes | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Heat in hands, feet and chest | <input type="checkbox"/> Lack of perspiration |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Hot flashes any time of day | <input type="checkbox"/> Take water to bed |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Thirsty | |
| <input type="checkbox"/> Feeling of being hot | | |
| <input type="checkbox"/> Feeling of being cold | | |

Overall Energy (LU, KI, SP QI)

- | | | |
|--|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Low energy | <input type="checkbox"/> Difficulty keeping eyes open during daytime |
| <input type="checkbox"/> General weakness | <input type="checkbox"/> Feel worse after exercise | |
| <input type="checkbox"/> Easily catch colds | | |

Heart

- | | | |
|---|---|--|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Wake un-refreshed |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mental confusion | |
| <input type="checkbox"/> Sores on tip of tongue | <input type="checkbox"/> Chest pain | |
| | <input type="checkbox"/> Frequent dreams | |

Lung

- | | | |
|---|---|---|
| <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Stiff shoulders |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Alternating chills and fever | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Overall achy feeling | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Dry throat | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Melancholy |
| <input type="checkbox"/> Dry nose | | |

Spleen

- | | | |
|---|--|---|
| <input type="checkbox"/> Low appetite | <input type="checkbox"/> Gurgling noise in stomach | <input type="checkbox"/> Pensive |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Fatigue after eating | <input type="checkbox"/> Over-thinking |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Easily bruised | <input type="checkbox"/> Worry often |
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> History of prolapsed organ |
| <input type="checkbox"/> Abdominal gas | | |

Digestion (SP, ST, LI, SI)

- | | | |
|--|--|---|
| <input type="checkbox"/> Loose stool | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Undigested food in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Black stool |
| <input type="checkbox"/> Incomplete bowel movement | <input type="checkbox"/> Mucous in stool | <input type="checkbox"/> Gas/flatulence |

Phlegm/Dampness

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> General sensation of heaviness | <input type="checkbox"/> Swollen hands | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Mental heaviness | <input type="checkbox"/> Swollen feet | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mental fogginess | <input type="checkbox"/> Chest congestion | <input type="checkbox"/> Fibroids |
| | <input type="checkbox"/> Nausea | <input type="checkbox"/> Nodules |

Stomach

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Burning sensation after eating | <input type="checkbox"/> Bleeding swollen or painful gums | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Large appetite | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiccoughs |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Vomiting |

Liver and Gall Bladder

- | | | |
|--|--|---|
| <input type="checkbox"/> Alternating diarrhea and constipation | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Muscle twitching |
| <input type="checkbox"/> Side of chest/rib pain | <input type="checkbox"/> Frustration | <input type="checkbox"/> Muscle cramping |
| <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sigh often | <input type="checkbox"/> Irritability | <input type="checkbox"/> High pitched ringing in ears |
| <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Stress | <input type="checkbox"/> Soft brittle nails |
| <input type="checkbox"/> Anger easily | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Gall stones |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Numbness | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle spasms | |
| <input type="checkbox"/> Feeling of lump in throat | <input type="checkbox"/> Neck tension | |
| | <input type="checkbox"/> Joint tightness/stiffness | |
| | <input type="checkbox"/> Shoulder tension | |

Eyes (LV)

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Itchy | <input type="checkbox"/> Gritty | <input type="checkbox"/> Far sighted |
| <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Floating black spots |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Decreased night vision | |
| <input type="checkbox"/> Dry | <input type="checkbox"/> Near sighted | |
| <input type="checkbox"/> Watery | | |

KI/UB

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Wake during night to urinate |
| <input type="checkbox"/> Easily broken bones | <input type="checkbox"/> Excessive hair loss | <input type="checkbox"/> Lack of bladder control |
| <input type="checkbox"/> Achy bones | <input type="checkbox"/> Early Greying of hair | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Sore knees | <input type="checkbox"/> Low pitched ringing in ears | <input type="checkbox"/> Easily startled |
| <input type="checkbox"/> Weak knees | <input type="checkbox"/> Diminished hearing | |
| <input type="checkbox"/> Cold sensation in knees | <input type="checkbox"/> Kidney stones | |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Bladder infections | |

Urination

- | | | |
|---------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Profuse | <input type="checkbox"/> Urgent |
| <input type="checkbox"/> Dark yellow | <input type="checkbox"/> Strong odor | <input type="checkbox"/> Frequent |
| <input type="checkbox"/> Clear | <input type="checkbox"/> Burning | |
| <input type="checkbox"/> Reddish | <input type="checkbox"/> Painful | |
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Dribbling | |
| <input type="checkbox"/> Scanty | <input type="checkbox"/> Difficulty urinating | |

Men's Health (Men Only)

- Prostate Problems
- Decreased Urine Flow
- Pain or Burning During Urination
- Impotence
- Erectile Dysfunction
- Reduced Sex Drive
- Seminal Emissions
- Genital Pain
- History of Testicular Cancer
- Other

Gynecology and Pregnancy (Women Only)

Please list how many:

Pregnancy's: _____ Live Births _____ Miscarriages _____ Abortions _____

At what age did your menstrual cycle start? _____ Date of last cycle? _____

What is the length of a normal cycle for you? _____ Has this changed recently? Y N

Do you use birth control? Y N If yes for how many years? _____

Date of last Pap smear: _____ Were the results normal? Y N

Are you premenopausal? Y N Postmenopausal? Y N Date of last Mammogram: _____

Have you ever had fertility problems? Y N

If yes, please describe: _____

Could you **currently** be pregnant? Y N

Please check all the following that apply:

- Light Periods
- Heavy Periods
- Irregular Cycle
- Clotting
- Spotting Between Cycle
- PMS
- Painful Breasts
- Bloating
- Back Ache
- Fatigue Before Period
- Unusual Vaginal Discharge
- Vaginal Dryness
- Painful Intercourse
- Hot Flashes
- Other