Arbor Vitae Acupuncture
Acupuncture and Chinese Herbal Medicine

Initial Patient Intake Form

The questions below have been chosen carefully to help make a complete holistic evaluation. Please take the time to answer as completely as possible.

Patient Full Name: ______________________________ Date: ____________________

Date of Birth: ________________ Age: __________ Occupation: ____________________

Address: ____

City: ____________________ State: ____________________ Zip: ______________

Home Phone: ______________________________ Cell Phone: ______________________

Work Phone: ______________________________ Email: __________________________

Preferred way of contacting you or leaving messages: ______________________________

Emergency Contact (Name, Relationship, & Phone number): __________________________

Physician (Name & Phone Number): ____

[ ] Single [ ] Married [ ] Divorced [ ] Significant Other [ ] Widowed

[ ] Caregiver for dependent Number of children: ____________________

Main reason for seeking treatment: ____

____

____

Current medical treatment and western medical diagnosis: __________________________

____

____

Current medications and dosages, including prescribed and over the counter: ____________

____

____

Current vitamins, herbs, and other supplements: __________________________________

____

____

Significant illnesses (please check all that apply):

[ ] Asthma [ ] Cancer [ ] Chronic Fatigue [ ] Depression
[ ] Diabetes [ ] Eating Disorder [ ] Heart Disease [ ] Hepatitis
[ ] HIV/AIDS [ ] Obesity [ ] Multiple Sclerosis [ ] High Blood Pressure

[ ] Seizures [ ] Shingles [ ] Hypo/Hyperthyroid [ ] Stomach ulcers
[ ] Stroke [ ] STD [ ] Rheumatic fever [ ] Pneumonia
[ ] Other: ______________________

Please check if any of the following are true:
[ ] I have a pacemaker
[ ] I am taking Coumadin/warfarin

Please list any surgeries you've had, including dates: ______________________

Please list any significant physical or emotional trauma (car accidents, sports injuries, death of family members, etc.)

Please list any allergies or food sensitivities:

Family Medical History (please specify family member):
[ ] Asthma: ______________________
[ ] Cancer: ______________________
[ ] Depression: ______________________
[ ] Diabetes: ______________________
[ ] Eating Disorder: ______________________
[ ] Heart Disease: ______________________
[ ] High Blood Pressure: ______________________
[ ] Hypo/Hyperthyroid: ______________________
[ ] Multiple Sclerosis: ______________________
[ ] Obesity: ______________________
[ ] Stomach ulcers: ______________________
[ ] Stroke: ______________________
[ ] Other: ______________________

Lifestyle (please check all that apply and note frequency of use):
[ ] Tobacco: ______________________
[ ] Alcohol: ______________________
[ ] Recreational Drugs: ______________________
[ ] Caffeinated beverages: ______________________

Please list types of exercise/physical activity and frequency: ______________________

Please list your dietary preferences and frequency of meals and snacks
[ ] Breakfast: ______________________
[ ] Lunch: ______________________
[ ] Dinner: ______________________
[ ] Snacks: ______________________

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Please check all that apply:

Head
[ ] Concussion
[ ] Headaches
[ ] Dizziness
[ ] Memory Loss
[ ] Migraines
[ ] Hair loss
[ ] Other ______________

Eyes
[ ] Blurred Vision
[ ] Pain
[ ] Dryness
[ ] Redness
[ ] Glasses/Contacts
[ ] Eyestrain
[ ] Color blindness
[ ] Night blindness
[ ] Cataracts
[ ] Floaters
[ ] Other ___________________

Ears
[ ] Poor hearing
[ ] Ringing in the ears
[ ] Frequent ear infections
[ ] Other ________________

Nose
[ ] Frequent colds
[ ] Sinus infections
[ ] Allergies
[ ] Nosebleeds
[ ] Runny nose
[ ] Other

Mouth
[ ] Gum inflammation
[ ] Canker sores
[ ] TMJ syndrome
[ ] Cold sores
[ ] Unusual tastes
[ ] Other_________________

Throat
[ ] Sore throat
[ ] Difficulty swallowing
[ ] Scratchy throat

Respiratory
[ ] Asthma
[ ] Bronchitis
[ ] Chest Pain
[ ] Cough
[ ] Coughing Blood
[ ] Difficulty breathing
[ ] Phlegm
[ ] Pneumonia
[ ] Wheezing
[ ] History of smoking
[ ] Other __________________

Heart and Thorax
[ ] Palpitations
[ ] Rapid heartbeat
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Tightness in chest
[ ] Arteriosclerosis
[ ] Heart attack
[ ]Other _______________

Circulation
[ ] Bruise easily
[ ] Cold hands/feet
[ ] Fainting
[ ] Phlebitis
[ ] Varicose Veins
[ ] Anemia
[ ] Other_______________________

Skin
[ ] Rashes
[ ] Hives
[ ] Dryness
[ ] Dandruff
[ ] Eczema
[ ] Hair loss
[ ] Acne
[ ] Purpura
[ ] Recent moles
[ ] Excessive sweating
[ ] Brittle nails
[ ] Fungal infections
[ ] Other___________________
[ ] Other_____________________

Gastrointestinal
[ ] Poor Appetite
[ ] Bad breath
[ ] Excessive Hunger
[ ] Excessive Thirst
[ ] Heartburn/Belching
[ ] Gas
[ ] Abdominal Pain
[ ] Parasites
[ ] Nausea
[ ] Vomiting
[ ] Constipation
[ ] Chronic Laxative use
[ ]Loose stools/diarrhea
[ ] Blood in stools
[ ] Hemorrhoids
[ ] Rectal Pain
[ ] Stomach Pain
[ ] Colitis or IBS
[ ] Gallstones
[ ] Other_______________

Urogenital
[ ] Frequent urination
[ ] Difficult urination
[ ] Burning urination
[ ] Retention of urine
[ ] Waking to urinate
[ ] Dribbling of urine
[ ] Bedwetting
[ ] Bladder weakness
[ ] Itching of genitals
[ ] Decreased libido
[ ]Impotency/Infertility
[ ] Kidney stones
[ ] Other_______________

Sleep
[ ] Insomnia
[ ] Night sweats
[ ] Drowsiness
[ ] Sleepwalking
[ ] Nightmares
[ ] Poor quantity
[ ] Poor quality
[ ] Other_______________

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Neuropsychological
[ ] Anxiety
[ ] Irritability
[ ] PMS
[ ] Depression
[ ] Easily Stressed
[ ] Poor memory
[ ] Worry
[ ] Fear
[ ] Seasonal Mood Disorder
[ ] Social Anxiety
[ ] Tics/Tremors
[ ] Other ______________________

Musculoskeletal
[ ] Spinal Pain
[ ] Low back pain
[ ] Joint Pain
[ ] Arthritis
[ ] Limited range of Motion
[ ] Disc degeneration
[ ] Osteoporosis
[ ] Numbness
[ ] Tingling
[ ] Other ______________________

Please rate how you feel about the following areas of your life (1=bad; 10=great):

	Great	Good	Fair	Poor	Bad	Comments:
Work	[ ]	[ ]	[ ]	[ ]	[ ]	____________________
Health	[ ]	[ ]	[ ]	[ ]	[ ]	____________________
Love	[ ]	[ ]	[ ]	[ ]	[ ]	____________________
Family	[ ]	[ ]	[ ]	[ ]	[ ]	____________________
Money	[ ]	[ ]	[ ]	[ ]	[ ]	____________________
Spirituality	[ ]	[ ]	[ ]	[ ]	[ ]	____________________
Self	[ ]	[ ]	[ ]	[ ]	[ ]	____________________
Diet	[ ]	[ ]	[ ]	[ ]	[ ]	____________________
Exercise	[ ]	[ ]	[ ]	[ ]	[ ]	____________________

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Women only

Age of first period: ______________________

Age of menopause (if applicable): ______________

How many days does your period last?: __________

How many days between periods?______________

Date of last ob/gyn exam: ___________________

[ ] Abortion
[ ] Miscarriage
[ ] Live birth
[ ] Birth Control Pills
[ ] Pain at ovulation
[ ] Cramps/Low back pain
[ ] Breast cancer
[ ] Fibrocystic breast
[ ] Ovarian cysts
[ ] Fibroids
[ ] Candida yeast
[ ] Vaginal Discharge
[ ] Vaginal odor
[ ] Spotting between periods
[ ] Amenorrhea
[ ] Dysmenorrhea
[ ] Irregular cycle
[ ] HPV
[ ] Other_________

Menstrual Flow:

[ ] Clots
[ ] Start and stop flow
[ ] Red
[ ] Brownish
[ ] Bright red
[ ] Flooding
[ ] Small amounts
[ ] Other

Please list any symptoms related to your period (pains, cravings, emotions, etc):

____

____

____

____

____

____

Men only

Date of last prostate check-up:___________________

PSA results: _____________________________

Lab results: _____________________________

[ ] Prostate Problems
[ ] Delayed stream
[ ] Dribbling
[ ] Incontinence
[ ] Retention of urine
[ ] Rectal dysfunction
[ ] Increased libido
[ ] Decreased libido
[ ] Premature ejaculation
[ ] Impotence
[ ] Back pain
[ ] Groin pain
[ ] Testicular pain
[ ] Other ___________