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)

- ☐ Diabetes
- ☐ Allergies
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Alcoholism
- ☐ Heart disease
- ☐ Obesity
- ☐ Nervous Illness
- ☐ High Blood pressure
- ☐ Mental Illness
- ☐ Other

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

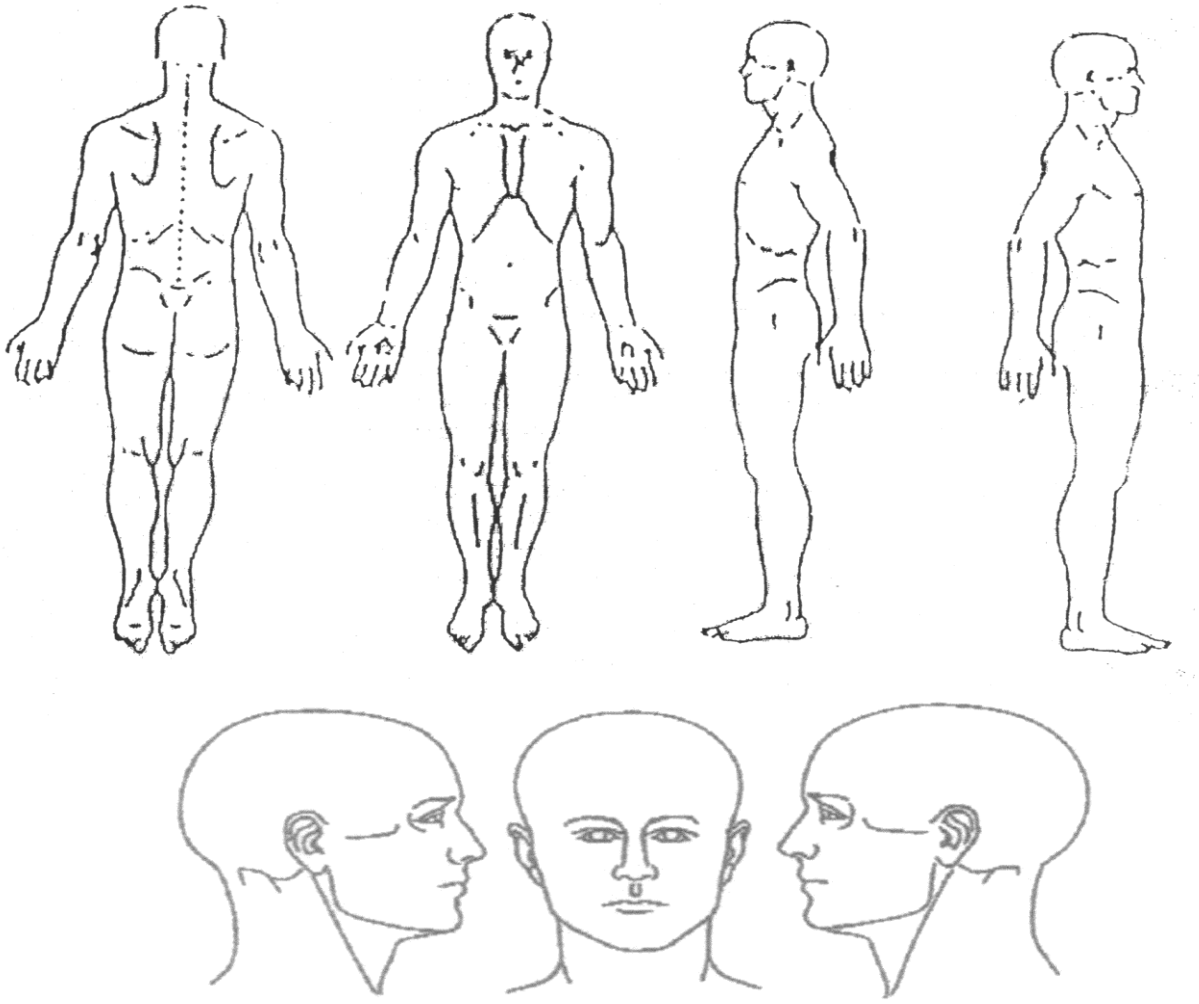
Soft drinks _____ per day/week

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:

- ☐ Sharp
- ☐ Cramping
- ☐ Fixed
- ☐ Burning
- ☐ Dull
- ☐ Aching
- ☐ Moving
- ☐ Other:_____

Does the following lessen the pain?

- ☐ Pressure
- ☐ Exercise
- ☐ Cold
- ☐ Heat
- ☐ Other:_____

Do the following worsen the pain?

- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ 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)

- ☐ Cold hands
- ☐ Cold feet
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Feeling of being hot
- ☐ Feeling of being cold
- ☐ Afternoon flushes
- ☐ Heat in hands, feet and chest
- ☐ Hot flashes any time of day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Take water to bed

Overall Energy (LU, KI, SP QI)

- ☐ Shortness of breath
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after exercise
- ☐ Difficulty keeping eyes open during daytime

Heart

- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain
- ☐ Frequent dreams
- ☐ Wake un-refreshed

Lung

- ☐ Nasal discharge
- ☐ Cough
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Allergies
- ☐ Alternating chills and fever
- ☐ Sneezing
- ☐ Overall achy feeling
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Sadness
- ☐ Melancholy

Spleen

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Gurgling noise in stomach
- ☐ Fatigue after eating
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Over-thinking
- ☐ Worry often
- ☐ History of prolapsed organ

Digestion (SP, ST, LI, SI)

- ☐ Loose stool
- ☐ Constipation
- ☐ Incomplete bowel movement
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Mucous in stool
- ☐ Undigested food in stool
- ☐ Black stool
- ☐ Gas/flatulence

Phlegm/Dampness

- ☐ General sensation of heaviness
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Fibroids
- ☐ Nodules

Stomach

- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad Breath
- ☐ Mouth sores
- ☐ Bleeding swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer
- ☐ Belching
- ☐ Hiccoughs
- ☐ Stomach pain
- ☐ Vomiting

Liver and Gall Bladder

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

Eyes (LV)

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near sighted
- ☐ Far sighted
- ☐ Floating black spots

KI/UB

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

Urination

- ☐ Normal color
- ☐ Dark yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning
- ☐ Painful
- ☐ Dribbling
- ☐ Difficulty urinating
- ☐ Urgent
- ☐ Frequent

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? _____

How many days between each menstrual cycle? _____ 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