

Fit Wellness Center - Acupuncture Intake Form

Name: _____ Date: _____

Main complaint/ reason for treatment today?: _____

Have you been given a diagnosis? If so, what? _____

What forms of treatment have you tried? Have they helped? _____

What makes the concern(s) better: _____

-worse: _____

Pain/Discomfort of main complaint: Least 1 2 3 4 5 6 7 8 9 10 Worst

History:

Have you ever received (check all that apply): Chiropractic Acupuncture Massage

With whom? _____

Date of last visit: _____ Why did you stop care? _____

Have you been treated by a Doctor for any health condition in the last year? Yes No

If yes, please describe: _____

Please list your family medical history: _____

List vitamins/supplements taken regularly: _____

List medications you take: _____

List any allergies or sensitivities to medications, drugs, and any foods or other substances: _____

Trauma: Have you ever had trauma from? Automobile Work Recreation Slips/Falls Other: Please explain how & when: _____

Broken any bones or sprain/strained any part of your body? Yes No How & when: _____

Any surgeries (ie joint replacements, pacemaker, etc) or hospitalizations? Yes No What & when: _____

Health Habits Check yes or no and circle day or week:

Tobacco smoking Yes No _____ packs per day/week type of tobacco _____

Coffee Yes No _____ cups per day/week Reg Decaf

Tea Yes No _____ cups per day/week Reg Herbal

Alcohol Yes No _____ drinks per day/week Wine Beer Liquor

Soft drinks Yes No _____ drinks per day/week Regular Diet

Artificial Sweeteners Yes No _____ packs per day/week

Glasses water/fluid per day _____ plain water _____ juice _____ other _____

What exercises/activities do you do and how often? _____

How many hours of sleep do you get per night? _____ Is it restful? _____

Do you have an adequate energy level? _____

Mark the stress level in your life (0 is the least, 10 is the most): _____

How much does stress affect you (0 is the least, 10 is the most)? _____

What is your job satisfaction (0 is the least, 10 is the most)? _____

What are the major stresses in your life presently? _____

How many hours per week do you work? _____ How many hours per week do you have for free time? _____

Favorite pastime/recreational activity: _____

Have you ever had any of the following? Please indicate "C" for current and "P" for past:

General

- Fever, chills, sweats
- Night sweats
- Insomnia
- Fatigue
- Nervousness/anxiety
- Irritability
- Depression

Medical History

- Cancer(type)_____
- Diabetes
- Thyroid disease
- Autoimmune Disease
- High blood pressure
- Heart Disease
- Respiratory Disease
- Hepatitis
- Seizures
- Drug Addiction
- Other_____

SKIN

- Non-healing sore
- Hives, rash
- Eczema, psoriasis
- Frequent infection or boils
- Warts
- Herpes:
 - lips
 - genital
 - zoster (shingles)
- Skin cancer or melanoma
- Brittle or weak nails
- Infected nails

ENDOCRINE

- Heat or cold intolerance
- Dry skin
- Change in hair growth or texture
- Excessive thirst or urination
- Hormone therapy
- Low or high sex drive
- Low blood sugar

HEAD-EYES-EARS-NOSE-THROAT

- Headache
 - sinus (allergy)
 - tension
 - migraine
- Eye disease or injury
- Vision impairment
- Loss of balance
- Dizziness or vertigo
- Loss of hearing
- Ear disease

- Ringing/buzzing in ears
- Chronic sinus trouble
- Nosebleeds
- Sore throats
- Tooth & gum problems
- Sores in mouth/ tongue

RESPIRATORY

- Frequent "colds"
- Difficulty breathing
- Pleurisy (pain with breathing)
- Chronic or frequent cough
- Asthma or wheezing
- Emphysema
- Spitting up blood
- Pneumonia

CARDIOVASCULAR

- Palpitation, irregular heart beat
- Chest pain or angina
- Shortness of breath with walking
- Shortness of breath lying down
- Swelling of hands, feet, or ankles
- Varicose veins

HEMATOLOGIC

- Anemia
- Excessive bleeding/bruising
- Slow to heal after cuts/bruising
- Phlebitis/blood clots in veins
- Mononucleosis

GASTROINTESTINAL

- Nausea and/or vomiting
- Bloating in stomach after eating
- Bloating or gas in lower abdomen
- Heartburn/indigestion
- Difficulty swallowing
- Ulcer (stomach or duodenal)
- Gallbladder disease or stones
- Liver trouble/hepatitis
- Constipation
- Diarrhea or loose stools
- Painful bowel movement
- Bloody or black stools
- Thin or ribbon like stools

GENITOURINARY

- Frequent urination
- Involuntary loss of urine
- Burning or painful urination
- Blood in urine
- Straining to urinate
- Hernia
- Sexually transmitted disease
- Kidney stones

- Kidney infections

FEMALE

- Currently pregnant
- PMS
- Menstrual cramping
- Uterine fibroids
- Hysterectomy
- Breast pain
- Breast lumps
- Abnormal PAP smear

MALE

- Testicular pain/swelling
- Discharge from penis
- Frequent night urination
- Prostate pain/swelling
- Impotence

NEUROLOGIC

- Fainting spells
- Epilepsy/Seizures
- Stroke or mini-stroke
- Paralysis
- Weakness of an arm or leg
- Insomnia or trouble sleeping

MENTAL EMOTIONAL

- Tendency towards:
- Sadness/grief/depression
 - Anger/irritability
 - Anxiety/fear
 - Mental overactivity

MUSCULOSKELETAL

- Joint swelling
- Arthritis or joint pain
- Weakness of muscles or joints
- Muscular pain or tension
- Muscle cramps
- Tendonitis
- Neck pain
- Shoulder pain
- Hand/wrist pain
- Carpal Tunnel
- Back pain
 - Low___ Middle___ Upper___
 - Hip pain
 - Sciatica
 - Soreness/weakness in lower body
- (back, knee, hip, ankle, foot)
- Knee pain
- Foot/ankle pain
- Other_____

Patient Signature_____ Date_____