Jennie King, LAc, LMT **General Oriental Medicine Intake**

Name: _____ Date: _____

United Health Care Insurance ID# _____

Cell Phone: _____ Work Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ Office Phone: _____

Emergency Contact: _____ Phone: _____

Occupation: _____ Have you had acupuncture before? Yes No

If yes, when & for what condition? _____

What brings you in today? _____
Please list your concerns in order of importance to you, how long it has affected you & any treatments.

1.	
2.	
3.	

MEDICAL HISTORY

List your current medications, vitamins or supplements:

List any known environmental or drug allergies

List any previous hospitalizations and/ or surgeries including dates.

Patient Name: _____ Date: _____

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Do you consider yourself to be in good general health? Yes No

If No, Why?

What was your most current blood pressure reading? _____
Please note if you have the following conditions using P = Past and C = Current

_____ Asthma
_____ Lung Problems
_____ Skin Problems
_____ Headaches
_____ Anemia
_____ Stroke
_____ Neurological
_____ Seizure / Epilepsy
_____ Spinal / Head Injury
_____ Depression/ psych problems
_____ Alcoholism
_____ Thyroid problems
_____ Weight problems
_____ Digestive Issues
_____ Cancer
_____ Contagious illness

_____ Breast problems
_____ Pace maker
_____ Low / High blood pressure
_____ Embolus, Blood clots
_____ Varicose veins
_____ Heart conditions
_____ Type 1 or 2 Diabetes
_____ Liver/ Gallbladder Disease
_____ Kidney / Bladder Disease
_____ Edema
_____ Hepatitis
_____ HIV / AIDS
_____ Herpes
_____ Osteoporosis
_____ Arthritis
_____ Strain/Sprain

Other: Please explain

FAMILY HISTORY **Age/s** **Health Issues**

Father _____
Mother _____
Sisters _____
Brothers _____
Paternal Grandparents _____
Maternal Grandparents _____

Patient Name: _____ Date: _____

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What is your weight now? _____ 6 months ago? _____ one year ago? _____

Do you exercise regularly? Yes No

What & how often? _____

Do you have a special diet now or in the past (vegetarian, vegan, Atkins, etc.)

_____

How many ounces of water do you drink per day? _____

Please describe your daily meals:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How many times per week do you use the following?

Coffee / Tea _____Soda _____

Alcohol _____ Tobacco _____

Have you been exposed to any know environmental toxins or hormones? Yes No

Mental / Emotional

Have you been treated for a mood disorder? Ie. panic attack, depression, anxiety, bipolar?
Yes No

If yes, what for, when and did you take any medications?

_____

What do you do to relax?	Hx of brain injury?	Seizures / Epilepsy
Hard to concentrate	Poor Memory	Vertigo

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Do you enjoy your work?	How would you rate your stress level?	What are your major stressors?

What would you consider the most significant events in your life?

1.	
2.	
3.	

Please **circle anything that currently applies** to you and **mark with an x** any past conditions:

Temperature

Cold hands and feet	Chills	Cold in the bones
Hot hands, feet	Hot flashes	Hot at night
No thirst	Very thirsty	Thirst no desire to drink

Head, Eyes, Ears, Nose & Throat

Impaired / Blurry Vision	Red /Dry Eyes	Poor Night Vision
Floaters	Eye Pain / Strain	Glaucoma
Glasses/Contacts	Impaired Hearing	Ear Ringing
Sinus Problems	Ear Aches	Frequent Sore Throat
Headaches / Migraines	TMD / Jaw problems	Nose Bleeds

Gastrointestinal

Indigestion	Gas	Nausea / Vomiting
Acid Reflux	Ulcers	Excessive Appetite
Changes in Appetite	No Appetite	Excessive Appetite
Diarrhea	Constipation	Alternating diarrhea / constipation
Poor Nutrient Intake	History of Parasites	Hemorrhoids

How often do you have a bowel movement? _____per day _____ per week

Patient Name: _____ Date: _____

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Any abnormal, color, blood, smell, consistency, mucous, or undigested food?

_____

Energy / Sleep

How would you rate your energy level? Low Medium High

Sudden drop of energy?	Heavy use of caffeine	Heavy Body
Shortness of breath	Wired in the evening	Dizziness / lightheaded
Difficulty falling asleep	Difficulty staying asleep	Wake not rested

Numbers of hours per night _____Wake _____ x/night @ _____ am / pm

Women's Health

Age at first menses	Last menses start date
How long is your average cycle?	# of days of flow
Is there a chance that you are pregnant now? Yes No	Have you gone through menopause? Date of last menses?

Symptoms

Cramps	Clots	Painful Periods
Heavy period	Light period	Irregular periods
Mid-cycle spotting	Fatigue with menses	Digestive Changes
Mood changes	Headaches with cycle	Breast Tenderness
Yeast Infections	Endometriosis	Fibroids
Cysts	PCOS	History of STD / What?

Fertility

Birth Control Pill	Other Birth Control	Fertility Medications
# of pregnancies	# of births	# of Abortions / Miscarriages

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Men's Health

Sexual difficulties / Pain	Prostate Problems	Testicular Pain / Swelling
BPH	Hx of cancer	Urinary Changes
Abnormal sperm analysis	Hx of STD / What?	

Genito-Urinary

Painful Urination	Frequent Urination	Incontinence
Urinary Tract Infections	Kidney Stones	Kidney Disease
Wakes to urinate How often?	Abnormal color, smell, or blood in urine	

Body Pain

Do you have body pain? Yes No Where?

Is it due to an accident or injury?	Chronic Pain / Illness?
Muscle Spasm	Numbness / Tingling
Postural problems	Congenital abnormalities

Is there anything else I should know about you that would help me to treat you?

Cancellation Policy

Please provide us with notice of cancellation at least **24 hours** in advance of your scheduled appointment. You may be charged if you late cancel or do not show up for your appointment. Please arrive on time to your appointment**. If you are more than 10 minutes late you will be asked to reschedule**. Thank you for your consideration in this matter.

Signature: _____Date: _____

Thank you for your time in filling out this form!

Patient Name: _____ Date: _____