CINCINNATI™
ACUPUNCTURE CLINIC

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Patient Intake Form

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

_____ _____ F _____ M _____
Name Last First Gender

_____/_____/_____ _____ _____
Date of Birth **Age** Occupation

_____ _____ _____ _____
Address **City** **State** **Zip Code**

(____)_____-_____ (____)_____-_____ _____
Telephone Home **Telephone** Work Email Address

Optional: Height_____ Weight_____ HIV_____ Hep_____

_____ (____)_____-_____ _____ (____)_____-_____
Physician Name Phone Number Chiropractor Name Phone Number

_____ _____ (____)_____-_____
In an Emergency Notify Name Relationship Phone

_____
How did you hear about our clinic?

_____
Have you been treated by acupuncture or Oriental medicine before?

Major Symptoms:

1. Main problem you would like us to help you with: _____
2. How long ago did this problem begin? _____

3. If you been given a diagnosis for this problem, what was it? _____
4. What kinds of treatments have you tried? _____
5. Are you currently receiving treatment for your problem? _____
   If so, please describe:_____
6. Has anything helped improving your problem? _____

Past Medical History:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Stroke
- ☐ Seizures
- ☐ Mental Illness
- ☐ Venereal disease
- ☐ HIV
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Rheumatic fever
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ High cholesterol
- ☐ Glaucoma
- ☐ Vein condition
- ☐ Migraine
- ☐ Thyroid disorder
- ☐ Bleeding tendency
- ☐ Multiple Sclerosis
- ☐ Nervous system disorder
- ☐ Other

Surgeries (type and date):_____
Significant trauma (auto accidents, falls, etc.):_____
Birth history (prolonged labor, forcepts delivery, caesarian section, other):_____
Childhood health:_____
Allergies (medications, foods, animals):_____
Do you have, or have ever had any infectious diseases? Yes_____ No_____
If so, please describe_____
Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last 3 month)
_____
Do you have a pacemaker or any metal devices in your body?_____
Do you have any reason to believe or know if you could be pregnant? Yes_____ No_____
If so, how far along are you?_____
Recent tests: (please indicate test results and date below)

- ☐ Physical
- ☐ Cholesterol
- ☐ Prostate
- ☐ Blood
- ☐ HIV/STD
- ☐ Pap smear
- ☐ Mammography

X-Ray/CAT Scans/MRI's/NMR's/Special Studies (reason and when):_____

Family Medical History:

Mother's Side_____
Father's Side_____
Siblings_____
If any of the above is deceased, what was the cause?_____

Review of Symptoms:

Please check if you have or have had experienced (in the last three months) any of the following diseases or conditions.

General:

- ☐Chills
- ☐Fever
- ☐Sweat easily
- ☐Night sweats
- ☐Localized weakness
- ☐Bleed or bruise easily
- ☐Peculiar tastes or smells
- ☐Strong thirst (cold/hot)
- ☐Thirst, no desire to drink
- ☐Fatigue
- ☐Sudden energy drop
  Time of day:_____
- ☐Edema
  Where:_____
- ☐Poor sleeping
- ☐Tremors
- ☐Poor balance
- ☐Cravings
- ☐Change in appetite
- ☐Poor appetite
- ☐Weight change
  Gain/Loss_____

Neuropsychological:

- ☐ Seizures
- ☐ Concussion
- ☐ Traumatic brain injury
- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Stroke
- ☐ Area of numbness
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Fainting
- ☐ Disorientation
- ☐ Irritability
- ☐ Anxiety/Worried
- ☐ Mood swings
- ☐ Nervousness
- ☐ Mental tension
- ☐ Sadness
- ☐ Easily angered
- ☐ Post-Traumatic stress disorder
- ☐ Poor memory
- ☐ Difficulty making decisions
- ☐ Depression
- ☐ Mania
- ☐ Panic attack
- ☐ Easily susceptible to stress
- ☐ Sleep disorder
- ☐ Difficulty concentrating

Have you ever been treated for emotional problems?
☐ Yes ☐ No

Have you ever considered or attempted suicide?
☐ Yes ☐ No

Any other neuropsychological problems? _____

Energy and Immunity:

- ☐ Slow wound healing
- ☐ Chronic infection
- ☐ Frequent cold/flu
- ☐ Chronic fatigue syndrome
- ☐ Seasonal allergies

Head, Eye, Ear, Nose, and Throat:

- ☐ Headaches

When:_____
Where:_____

- ☐ Facial Pain
- ☐ Dizziness
- ☐ Glasses/Lens
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Colorblindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eyestrain
- ☐ Cataracts
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nosebleed
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throat
- ☐ Hoarseness
- ☐ Sores on lips/tongue/gums
- ☐ Difficulty swallowing
- ☐ Other head/neck problems

Skin and hair:

- ☐ Rushes
- ☐ Itchiness
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Easy bruising
- ☐ Warts
- ☐ Acne
- ☐ Other

Respiratory:

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when laying down
- ☐ Phlegm
  Color? _____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other

Cardiovascular:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing
- ☐ Varicose veins/phlebitis
- ☐ Rheumatic fever
- ☐ Other

Gastrointestinal:

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/acid reflux
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea/loose stool
- ☐ Constipation
- ☐ Alternative constipation and diarrhea
- ☐ Hernia
- ☐ Chronic laxative use
- ☐ Blood in stool
- ☐ Black stool
- ☐ Strong smell in stool
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain/prolapse
- ☐ Hemorrhoids
- ☐ Little appetite
- ☐ Strong appetite
- ☐ Huger but no desire to eat
- ☐ Food cravings
- ☐ Regurgitation
- ☐ Weight loss
- ☐ Weight gain
- ☐ Anorexia nervosa
- ☐ Bulimia
- ☐ Parasites
- ☐ Gallbladder problems

- ☐ Bowel movement:
  Frequency: _____
  Color: _____
  Odor: _____
  Texture/Form: _____

Genito-Urinary:

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Decrease inflow
- ☐ Dribbling
- ☐ Urinary incontinence/retention
- ☐ Kidney stones
- ☐ Bladder/kidney infections
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sore genitals

Do you wake to urinate?
☐ Yes ☐ No
How often?: _____
What color is your urine? _____

- ☐ Other

Musculoskeletal:

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle/hill pain
- ☐ Joint/bone problems
- ☐ Osteoporosis
- ☐ Sprain of joints
- ☐ Joint instability
- ☐ Herniated disk
- ☐ Arthritis
- ☐ Muscle cramps
- ☐ Muscular weakness
- ☐ Muscular atrophy
- ☐ Genera aches
- ☐ Other

Female Health:

- ☐ Irregular cycle
- ☐ Heavy flow
- ☐ Light flow
- ☐ Clots in menstrual blood
- ☐ Bleeding between cycles
- ☐ Painful period (is pain before, during and/or after period? _____
- ☐ Menstrual related moodiness
- ☐ Menstrual related breast tenderness
- ☐ Hot flashes
- ☐ Vaginal dryness
- ☐ Breast lumps/cysts
- ☐ Nipple discharge
- ☐ Uterine fibroids
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Unusual vaginal discharge/odor
- ☐ Frequent yeast infections
- ☐ Decreased libido
- ☐ Menopause

Age and year: _____

- ☐ Postcoital bleeding
- ☐ Vaginal sores

Do you use birth control?
☐ Yes ☐ No
What type and how long?
_____

- ☐ Fertility problems

# of pregnancies: _____
# of birth: _____
premature birth:_____
of miscarriages: _____
# of abortions:_____
# of caesarian births:_____
# of difficult deliveries:____
Age of first menses:_____
Duration of period:
Days:_____
Cycle-Days: _____
Last menses start date:_____
Last pap smear date: _____

- ☐ Other

Male Health:

- ☐ Prostate problems
- ☐ Change in sex drive
- ☐ Rashes/itching
- ☐ Erection difficulty
- ☐ Low sperm count/motility.
- ☐ Premature ejaculation
- ☐ Decrease libido
- ☐ Groin pain
- ☐ Penile discharge
- ☐ Other

Endocrine:

- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Hypoglycemia
- ☐ Diabetes mellitus
- ☐ Night sweats
- ☐ Feeling hot or cold
- ☐ other

Lifestyle:

Do you have an exercise routine? _____
How many hours per night do you sleep on average? _____
Do you wake rested? Yes ____ No ____
What time do you usually go to bed? _____

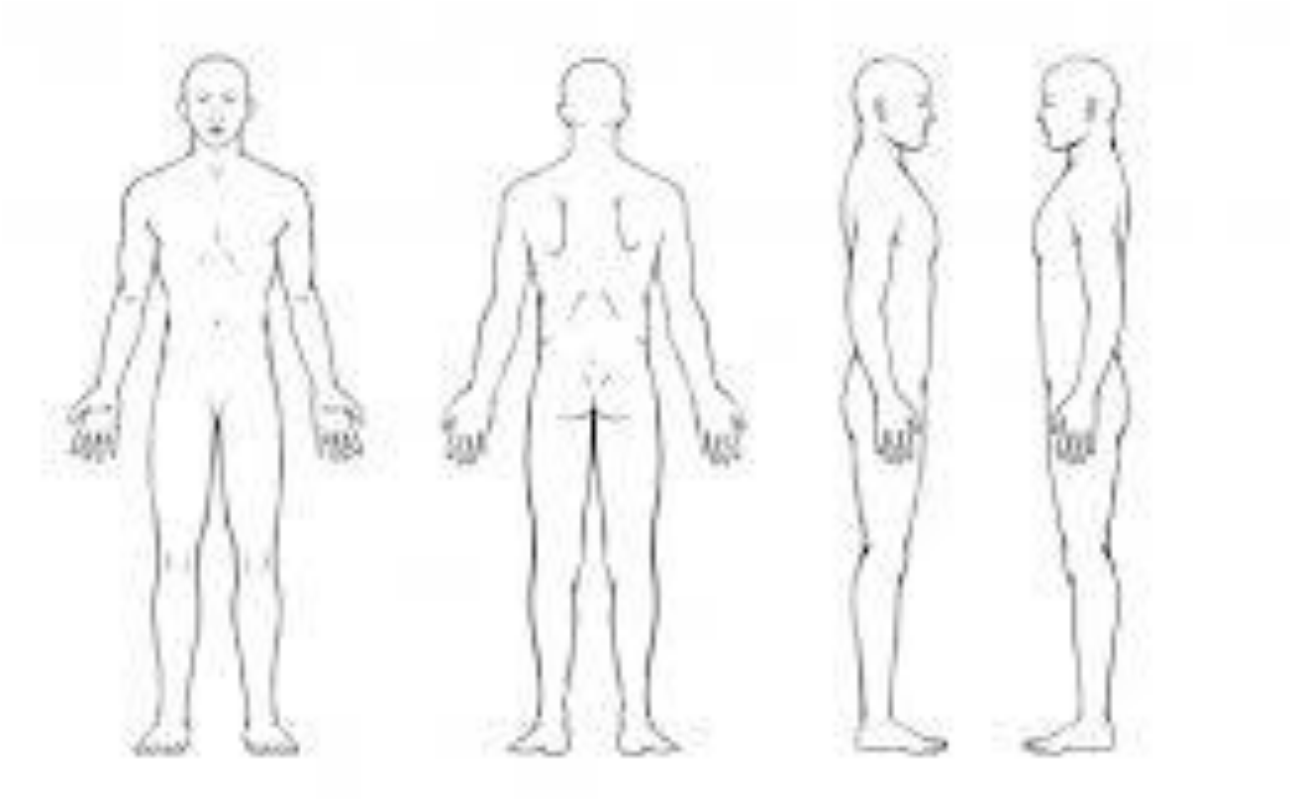
Please mark your current use levels of the following:
Tobacco frequently___ occasionally___ never___ Number of cigarettes per day_____Age started _____
Alcohol frequently___ occasionally___ never___ Number of drinks per week_____ Type of drinks _____
Caffeine frequently___ occasionally___ never___ Number of cups per day_____ Type of drinks _____
Other frequently_____ occasionally_____ never_____ Describe _____
Do you have any current or past problems with addiction or substance abuse? Yes____ No_____
Substance_____ Amount_____ When did you quit?_____

How many hours per week do you work? _____
Do you enjoy what you do? Y / N
How many hours a day do you spend sitting or driving? _____
Interests and hobbies? _____
How many glasses of water do you drink per day? _____
Do you typically eat at least 3 meals per day? Y / N If No, how many? _____
Your typical daily diet? _____
Are you a vegetarian or vegan? Y / N If yes which one and how long?_____

Energy level: _____
Stress level: _____
Current emotional health: _____
Current quality of life: _____
Current relationship quality: _____
Current predominant emotion: _____

Indicate painful or distressed area:

Please circle on the diagram any areas of concern.



Is the pain: ❑Sharp ❑Burning ❑Aching ❑Cramping ❑Dull ❑Moving ❑Fixed ❑Other:_____

Do the following improve the pain? ❑Pressure ❑Cold ❑Heat ❑ Exercise ❑ Other_____

Do the following worsen the pain? ❑Pressure ❑Cold ❑Heat ❑Other:_____