Claudia Olson-Acupuncture

Patient Intake Form

Personal Information Date_____

Name_____ Sex: M F Date of Birth_____

Address_____ City _____State _____Zip_____

Telephone: Home_____ Cell_____

Email _____ Method you prefer to be contacted_____

Emergency Contact _____Relationship_____

Emergency Contact Telephone: Home_____ Cell_____

Are you: Single Married Partnered Divorced/Separated Widowed

Height_____ Weight_____ Occupation_____

Previous acupuncture? Yes No

What is your reason for seeking acupuncture?_____

_____

_____

Previous treatment for this condition:_____

_____

Medications/Supplements	Dosage	For what condition?

Medical History (Hospitalizations, emergency room visits, surgeries, serious medical conditions, injuries)

Year	Illness/Surgery/Injury

Lifestyle Habits (For each, please indicate how much, how often, or how many, and if/when you quit.)

Cigarettes (packs/day)_____ Coffee/Tea (cups/day)_____

Alcohol (drinks/week)_____ Soda (diet & regular)_____

Water (ounces/day)_____ Recreational Drug use_____

Exercise (type, frequency, duration)_____

_____

Family History (Please complete as best as you can. Mark with an X or with the date as appropriate.)

	self	mother	father	sibling	spouse/partner	children
Good health						
Adopted						
Cancer/tumors						
Diabetes						
Thyroid condition						
Kidney disorder						
High blood pressure						
Heart disease/stroke						
Blood disorder/anemia						
Seizures						
Allergies						
Alcohol &/or drug abuse						
Mental illness						
Liver disease/hepatitis						
Musculoskeletal disorder						
HIV/AIDS						
Deceased	N/A					

Current & Past Conditions/Symptoms/Traumas: Please check all that apply.

GENERAL
___trouble falling &/or staying asleep
___nightmares/dreams
___fatigue
___poor memory
___strongly like cold/hot drinks
___recent weight gain/loss
___cold hands &/or feet
___chills/fevers
___bad breath

HEAD & NECK
___headaches/migraines
___stiff neck
___dizziness
___fainting
___swollen glands
___ other (describe)
_____

EARS
___ringing
___hearing loss
___infections
___earache
___vertigo
___other (describe)
_____
Last hearing exam_____

EYES
___glasses/contacts
___blurred &/or double vision
___poor night vision
___floaters or spots
___eye inflammation
___glaucoma/cataracts
___"lazy" eye
___other (describe)
_____
Last eye exam_____

NOSE, MOUTH & THROAT
___sinus infections
___allergies/hay fever
___frequent sore throats or colds
___difficulty swallowing
___mouth/tongue ulcers
___nosebleeds
___dry nose &/or mouth
___nasal congestion
___excessive phlegm
___TMJ or facial pain
___gum or dental problems
___other (describe)
_____
Last dental exam_____

SKIN
___hives/rashes
___eczema/psoriasis
___night sweats
___excess sweating
___dry skin/itching
___bruising easily
___changes in moles/lumps
___other(describe)
_____

RESPIRATORY
___difficulty breathing
___asthma/emphysema/wheezing
___chronic cough -- wet/dry
___coughing up phlegm &/or blood
___shortness of breath
___pneumonia

MUSCULOSKELETAL
___joint pain/swelling
___sore muscles/weakness
___difficulty walking/moving
___pain (describe)
_____
___other (describe)
_____

CARDIOVASCULAR
___high/low blood pressure
___chest pain/tightness
___palpitations
___irregular heart beat
___poor circulation
___swollen ankles
___anemia
___heart disease/attack
___heart murmur
___other (describe)
_____

GASTROINTESTINAL
___nausea/vomiting
___indigestion
___stomach pain
___diarrhea
___constipation
___poor appetite
___excessive hunger
___gas
___acid regurgitation
___bloating
___bloody stools
___other (describe)
_____

URINARY
___painful urination
___frequent/urgent urination
___blood in urine
___incontinence
___incomplete urination
___bed-wetting
___urinary tract/kidney infections
___other (describe)
_____

NEUROLOGICAL
___seizures
___tremors
___numbness/tingling
___paralysis
___coordination problems
___pain
___other (describe)
_____

MENTAL/EMOTIONAL
___depression
___mood swings
___anxiety/frequent worry
___irritability/anger/frustration
___losing temper
___difficulty relaxing
___loneliness
___sensitivity
___shyness
___frequent crying
___compulsive behaviors
___difficulty focusing
___hopeless outlook
___suicidal thoughts
___other (describe)
_____

INFECTION SCREENING
(circle self &/or partner)
___HIV risk: self partner
___tuberculosis: self partner
___hepatitis risk: self partner
___ sexually transmitted disease:
self partner

GENITAL (female)
___currently pregnant
___# pregnancies
___# live births
___# miscarriages
___#abortions
___menopause
___irregular periods
___menstrual pain
___excessive blood flow
___breast tenderness
___abnormal pap smear/infections
___pain/itching of genitals
___lumps/cysts in breasts
___increased libido
___decreased libido
___other (describe)
_____
Last exam_____

GENITAL (male)
___impotence
___premature ejaculation
___nocturnal emissions
___pain/itching of genitals
___lumps in testicles or breasts
___increased libido
___decreased libido
___other (describe)
_____
Last exam_____

TRAUMAS (please list briefly)
_____

Signature: _____
Print Name: _____ Date:_____