Gruene Dragon
Acupuncture &
Oriental Medicine

Patient Intake Form

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Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have any questions, please ask. Thank you.

Full Name _____ Sex ☐ F ☐ M Date _____

Address: Street _____ City _____ State/Zip _____

Date of Birth _____ Age _____ Occupation _____

Main Phone # _____ Other Phone # _____

E-mail address _____ Allow email contact ☐ Yes ☐ No

Emergency contact name & phone _____ Martial status _____ # of children _____

Family physician _____ Chiropractor _____

Do you have health insurance? ☐ Yes ☐ No If yes, name of insurance company _____

Does your insurance cover acupuncture? ☐ Yes ☐ No Have you ever been treated by acupuncture before?

How did you find out about our clinic?

☐ Direct mail ☐ Location of walk by ☐ Friends/Relatives(name)
☐ Yellow Pages ☐ Periodicals ☐ Website
☐ Referred by _____ ☐ Other (please specify)_____

Main problems: _____

What diagnosis, if any, have you received for this problem?_____

When did this problem begin?_____ What are the causes of this problem?_____

To what extent does this problem interfere with you daily activities (work, sleep, sex, etc...)?_____

What kind of treatment have you tried?_____

What makes this problem worse?_____What makes this problem better?_____

Is there anybody in your family with the same/similar problems?_____Remarks and additional information:

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Surgeries: _____Hospitalization:_____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc... and their dosages):

_____

Occupation: _____ Do you usually work ☐ indoors ☐ outdoors

Occupational stress (chemical, physical, psychological, etc):_____

Personal Height_____ Weight now_____ Weight one year ago_____

Weight maximum _____@ Year _____

Habits Do you smoke? ☐ Yes ☐ No What _____ How many per day? _____Since when?_____

Please describe any use of drugs for non-medical purposes:_____

Do you exercise regularly ☐ Yes ☐ No Please describe your exercise program:_____

How many hours do you sleep in general?_____ What time do you usually go to bed?_____

Diet How much coffee do you drink?_____cups/day Colas_____number/day Tea_____cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week?_____

How much water do you drink per day? _____

Are you a vegetarian ☐ Yes ☐ No ☐ Yes, but not so strict Do you eat a lot of spicy food ☐ Yes ☐ No

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

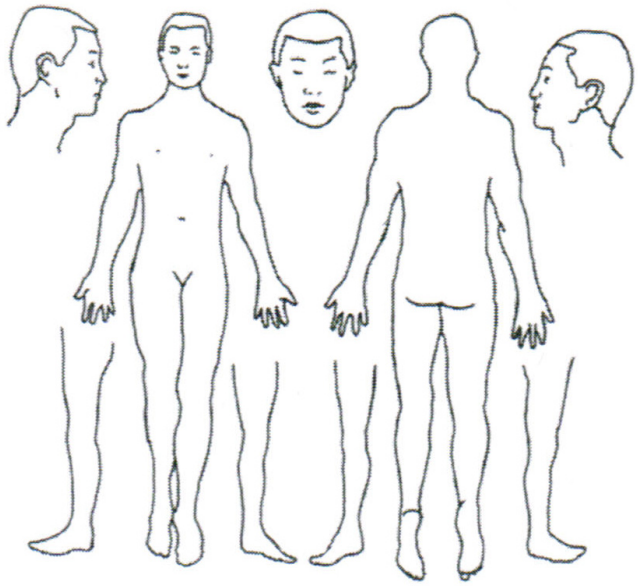
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



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

General ☐ **Poor appetite** ☐ **Poor sleep** ☐ **Fatigue** ☐ **Fever** ☐ **Chills**

☐ **Night sweats** ☐ **Sweat easily** ☐ **Tremors** ☐ **Cravings** ☐ **Change in appetite**

☐ **Poor balance** ☐ **Bleed or bruise easily** ☐ **Localized weakness** ☐ **Weight loss** ☐ **Weight gain**

☐ **Peculiar tastes** ☐ **Desire hot food** ☐ **Desire cold food** ☐ **Strong thirst (cold or hot drinks)**

☐ **Sudden energy drop (what time of day)** _____ **Favorite time of year** _____ **Worst time of year**_____

Skin & hair
- [ ] Rashes
- [ ] Ulcerations
- [ ] Hives
- [ ] Itching
- [ ] Eczema
- [ ] Pimples
- [ ] Acne
- [ ] Dandruff
- [ ] Dry Skin
- [ ] Recent moles
- [ ] Purpura
- [ ] Change in hair or skin texture
- [ ] Other?
- [ ] Loss of hair

Musculoskeletal
- [ ] Joint disorders
- [ ] Muscle weakness
- [ ] Tremors
- [ ] Neck pain
- [ ] Hip pain
- [ ] Cold hands/feet
- [ ] Difficulty walking
- [ ] Spinal curvature
- [ ] Back pain
- [ ] Hernia
- [ ] Other?
- [ ] Numbness
- [ ] Tingling
- [ ] Paralysis
- [ ] Neck tightness
- [ ] Shoulder pain
- [ ] Hand/wrist pain
- [ ] Knee pain
- [ ] Joint sprain
- [ ] Swelling of hands/feet
- [ ] Pain/sorenessin the muscles

Head, eyes, ears, nose, and throat
- [ ] Dizziness
- [ ] Concussions
- [ ] Migraines
- [ ] Eye strain
- [ ] Eye pain
- [ ] Color blindness
- [ ] Night blindness
- [ ] Poor visions
- [ ] Blurry vision
- [ ] Earaches
- [ ] Ringing in ears
- [ ] Poor hearing
- [ ] Spots in front of eyes
- [ ] Sinus problems
- [ ] Nose bleeding
- [ ] Sore throat
- [ ] Grinding teeth
- [ ] Teeth problems
- [ ] Glasses/lens
- [ ] Cataracts
- [ ] Facial pain
- [ ] Other?
- [ ] Jaw clicks
- [ ] Sores on lips/ tongues
- [ ] Difficulty swallowing

Cardiovascular
- [ ] Highblood pressure
- [ ] Low blood pressure
- [ ] Chest pain
- [ ] Palpitation
- [ ] Phlebitis
- [ ] Irregular heartbeat
- [ ] Rapid heartbeat
- [ ] Varicose veins
- [ ] Fainting
- [ ] Other?

Respiratory
- [ ] Cough
- [ ] Coughing blood
- [ ] Wheezing
- [ ] Difficulty breathing
- [ ] Bronchitis
- [ ] Pneumonia
- [ ] Chest pain
- [ ] Production of phlegm - What color? _____

Gastrointestinal
- [ ] Nausea
- [ ] Vomitting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Belching
- [ ] Black stools
- [ ] Blood in stools
- [ ] Indigestion
- [ ] Bad breath
- [ ] Hemorrhoids
- [ ] Gas
- [ ] Rectal pain
- [ ] Parasites
- [ ] Chronic laxative use
- [ ] Gallbladder problems
- [ ] Abdominal pain/cramps

Bowel movements: Frequency_____ Color_____ Odor_____ Texture/form_____

Neuro-psychological
- [ ] Loss of balance
- [ ] Loss of coordination
- [ ] Concussion
- [ ] Depression
- [ ] Anxiety
- [ ] Stress
- [ ] Bad temper
- [ ] Bi-polar

Genito-urinary
- [ ] Painful urination
- [ ] Frequent urination
- [ ] Blood in urine
- [ ] Urgency to urinate
- [ ] Kidney stones
- [ ] Unable to hold urine
- [ ] Dribbling
- [ ] Pause in flow
- [ ] Genital pain
- [ ] Genital itching
- [ ] Genital rashes
- [ ] STD
- [ ] Frequent Urinary tract infections
- [ ] Other

FEMALE

- ☐ Frequent vaginal infections
- ☐ Pelvis infection
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Irregular periods
- ☐ Clots
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Fertility problems
- ☐ Hot flashes
- ☐ Moodiness related to periods
- ☐ Pain/cramps prior/during periods

_____Number of pregnancies _____Number of births _____Miscarriages _____Abortions

_____Premature births _____C-section _____Difficult delivery

First date of last period_____ Age of first period_____ Duration of periods_____days, cycle ____days

Do you practice birth control? ☐ Yes ☐ No If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long?_____

MALE

- ☐ Prostate problems
- ☐ Discharge
- ☐ Erectile dysfunction
- ☐ Ejaculation problems
- ☐ Prostate problems
- ☐ Fertility problems
- ☐ Painful/swollen testicles
- ☐ Other
- ☐ Frequent seminal emission

Signature: ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

_____ _____

Signature Date