East West Acupuncture & Wellness Center, Inc.

Patient Intake Form

Date: _____/_____/_____

How did you hear about us? ( )Ad ( ) Healthcare Referral ( ) Friend/Family

Whom may we thank for the referral?_____

Name_____ DOB___/_____/_____ Age_____ Sex: ( ) Male ( ) Female

Address_____

City, State, Zip_____

Telephone (home)_____(work)_____(cell)_____

Email Address_____Allow Email contact by East West? ( ) Yes ( ) No

Emergency Contact name & number_____

Marital Status_____Occupation_____

Physician & number_____Chiropractor & number_____

Have you had acupuncture before?_____ Was it helpful?_____Was it pleasurable?_____

Have you taken Herbal Prescriptions before?_____Are you willing to take herbs at this time?_____

Main Complaint that you are seeking treatment?_____

When did this problem begin?_____What caused this problem?_____

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

What treatments have you tried?_____

What makes it better?_____What make it worse?_____

Surgeries & dates_____

Medications:	For what Condition:
_____	_____
_____	_____
_____	_____
_____	_____

Allergies (drug, chemical, environmental)_____

_____

Medical History:

Have you had any of these conditions now or in the past? Please check all that apply.

( ) AIDS/HIV	( ) Alcoholism	( ) Allergies	( ) Asthma
( ) Arthritis	( ) Anemia	( ) Cancer	( ) Diabetes Type 1 or 2
( ) Drug Addictions	( ) Depression	( ) Digestive Disorders	( ) Emphysema
( ) Fibromyalgia	( ) Herpes	( ) Hepatitis A/ B / C	( ) Heart Disease
( ) High Blood Pressure	( ) High Cholesterol	( ) Joint Replacements	( ) Lyme's Disease
( ) Multiple Sclerosis	( ) Pacemaker	( ) Seasonal Allergies	( ) Seizures
( ) Sinus Infections	( ) Tuberculosis	( ) Other_____	

_____

Personal History:

Height_____Weight Now_____Weight 1 year ago_____Max Weight_____When_____

Do you smoke?_____What?_____How much per day?_____For how long?_____

Do you exercise regularly?_____If so, how often & what type?_____

Do you drink Coffee?_____How much?_____ Cola?_____How much?_____

Tea?_____How much?_____Water?_____How much?_____

Alcoholic Drinks?_____Type?_____How much?_____

Are you a vegetarian?_____Do you eat spicy food?_____

Average Daily Diet:

Morning_____

Afternoon_____

Evening_____

Snacks_____

How is your energy?_____

What time of day is it the highest?_____Lowest?_____

Emotions/Stress/Sleep:

Do you experience any of the following? Check all that apply.

( ) Panic Attacks	( ) Depression	( ) Anxiety	( ) Anger / Short temper
( ) Poor Memory	( ) Difficult Concentration	( ) Fatigue	( ) Boredom

How do you relax or relieve stress?_____

How many hours do you sleep a night?_____How long does it take you to go to sleep?_____Dreams? Y/ N

Do you wake up at night?_____How many times do you wake up?_____

Do you know what wakes you up?_____

Are you able to go right back to sleep?_____If not, how long does it take to fall back to sleep?_____

Gastrointestinal:

I have or have had: check all that apply.

( ) Belching ( ) Acid Reflux ( ) Heartburn ( ) Gas ( ) Hernia

( ) Nausea ( ) Vomiting ( ) Vomiting Blood ( ) Stomach Pain ( ) Ulcers

Bowel Movements: How often?_____Times per day OR _____times per week

Bowel Movement Qualities: check all that apply

( ) Burning sensation ( ) Irregular ( ) Constipation ( ) Diarrhea ( ) Gas

( ) Hemorrhoids ( ) Undigested Foods ( ) Hard/Dry Stool ( ) Painful Bowel Movements

Urinary:

Urination: How often_____times per day Color: ( ) Clear ( ) Yellow ( ) Dark yellow/orange

I have or have had: check all that apply

( ) Trouble starting stream ( ) Stop & Go Stream ( ) Frequent Urination ( ) Incontinence

( ) Pain ( ) Burning ( ) Blood in Urine ( ) Kidney Stones

( ) Dribbling with sneezing/cough ( ) Urinary Tract Infections

Women:

Age at start of Menses_____ Number of Days of Cycle_____Days of Bleeding_____

Date of last Menses_____Date Menopause or Hysterectomy_____

Describe your flow as: Light / Medium / Heavy Color of Blood: Pale / Red / Dark Red Clots:_____

Do you experience emotional changes before or during your periods?_____

Do you experience cramping or discomfort before or during your periods?_____

Any vaginal discharge?_____Color_____Itchy/Burning_____

Number of Pregnancies_____Miscarriages_____Hormones/Birth Control_____

Men:

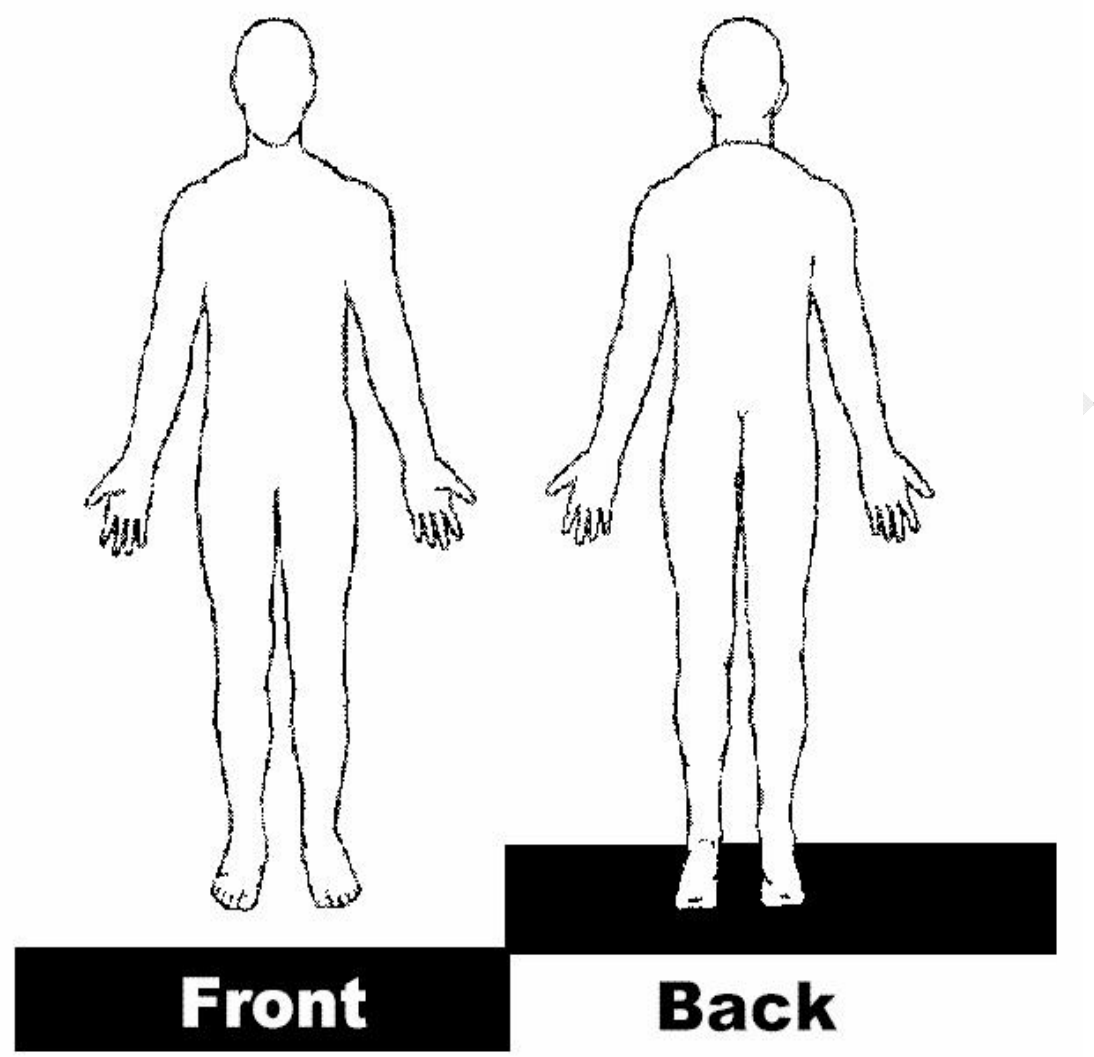
I have or have had: check all that apply

( ) Prostatitis ( ) Impotence ( ) Blood or Mucous Discharge

( ) Other:_____

Pain:

Please circle areas of pain or discomfort.



Eyes, Ears, Nose, Throat & Head:

I have or have had: check all that apply

( ) Frequent colds	( ) Frequent Sore Throat	( ) Chronic cough	( ) Coughing up Mucous
( ) Coughing up blood	( ) Difficult inhaling	( ) Shortness of Breath	( ) Asthma
( ) Nose bleeds	( ) Painful/Red eyes	( ) See Spots/Floaters	( ) Dizziness
( ) Cold Sores	( ) Bleeding gums	( ) Dry Mouth	( ) Ringing in the ears

( ) Frequent Headaches/Migraines, describe:_____

Cardiovascular:

I have or have had: check all that apply

( ) Chest Pain	( ) Palpitations	( ) Varicose Veins	( ) Phlebitis
( ) Cold Hands & Feet	( ) Irregular Heartbeat	( ) Poor Circulation	( ) Other:_____

Skin & Hair:

I have or have had: check all that apply

( ) Dry Skin	( ) Skin Rashes	( ) Eczema	( ) Psoriasis
( ) Acne	( ) Hives	( ) Hair loss	( ) Premature Graying

Miscellaneous:

Please let us know if there is any additional information that may help us serve you better._____

Thank you for helping us to better help you in your quest for health!