



Advanced Acupuncture Center

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www.WangAcupuncture.com

Intake Form

Name Last- _____ First _____ Middle _____ SSN # _____ / _____ / _____

Date of Birth _____ / _____ / _____ Gender F _____ M _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Telephone: Home (_____) _____ - _____ Work (_____) _____ - _____ Ext. _____

Marital Status: _____ Education (Highest grade or degree achieved) _____

Option: Height _____ Weight _____ HIV _____ HbsAg _____

How did you hear about our clinic? _____

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

Name of your physician: _____ Tel: _____

Address of your physician: _____ City _____ State _____ Zip Code _____

In an Emergency Notify Name _____ Relationship to client _____

Phone (Day) (_____) _____ - _____ (Evening) (_____) _____ - _____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1. Main problem you would like us to help you with: _____
2. How long ago did this problem begin? _____
3. Have you been given a diagnosis for this problem? If so, what? _____
4. What kinds of treatment have you tried? _____
5. Are you currently receiving treatment for your problem? _____ If so, please describe:

6. Does anything improve your problem? _____

PAST MEDICAL HISTORY

Illnesses: _____

Surgeries _____

Significant Trauma (Auto accidents, falls, etc.) _____

Do you have, or have you 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 three months)

Allergies:

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

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

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) _____
Childhood health _____
Location of upbringing (Geographically prone to certain diseases, habits, etc.) _____
Current Emotional Health _____
Current Quality of Life _____
Current Relationship/Quality _____
Current Predominant Emotion _____
Occupation _____ Stress Level _____
Have you had any unusual stresses recently? _____
Favorite time of year (body type) _____ Worst _____
Hobbies & Recreational Habits _____
Do you have a regular exercise program? Yes No If so, please describe: _____
Have you traveled abroad in the past year? Yes No Where? _____
If applicable, please describe smoking or alcohol intake : _____

NEUROPSYCHOLOGICAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Easily Angered |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Mania |
| <input type="checkbox"/> Easily Susceptible to Stress | | |

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____
Any nervous habits? _____

PREGNANCY & GYNECOLOGY

___ Age at First Menses	___ Number of Pregnancies	<input type="checkbox"/> Birth Control?
___ Period between Menses	___ Number of Births	What type? _____
___ Duration of Menses	___ Miscarriages	How long? _____
<input type="checkbox"/> Unusual Character	___ Abortions	<input type="checkbox"/> Fertility Problems
<input type="checkbox"/> Heavy or <input type="checkbox"/> Light	<input type="checkbox"/> Difficult Births	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Vaginal Sores
<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Clots	

First Date of Last Menstrual Cycle ____/____/____ Date of Last Pap Smear ____/____/____
Do you experience changes in Body and/or Psyche prior to menstruation ? _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

- | | | |
|----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Tremors | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Seizures | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sudden energy drops? |
- What time of Day? _____
- | | | |
|--|--|--|
| <input type="checkbox"/> Poor Sleep/ Insomnia | <input type="checkbox"/> Day Sweating | <input type="checkbox"/> Strong thirst for Hot or Cold drinks? |
| <input type="checkbox"/> Dream Disturbed Sleep | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Localized Weakness |
| <input type="checkbox"/> Mania | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Bleeding or Bruising |
| <input type="checkbox"/> Emotional Changes | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Joint Pain |

CARDIOVASCULAR

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty in Breathing | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Cold Hands/Feet | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Phlebitis | |

RESPIRATORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain w/ Deep Breaths | <input type="checkbox"/> Difficulty in Breathing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Easily Winded w/ Exertion when laying down | | <input type="checkbox"/> Coughing Blood |
| <input type="checkbox"/> Production of phlegm | What Color? _____ | |

GASTROINTESTINAL

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Abdominal Pain/ Cramps | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Parasites | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Belching | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Blood in Stools |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Hemorrhoids | |

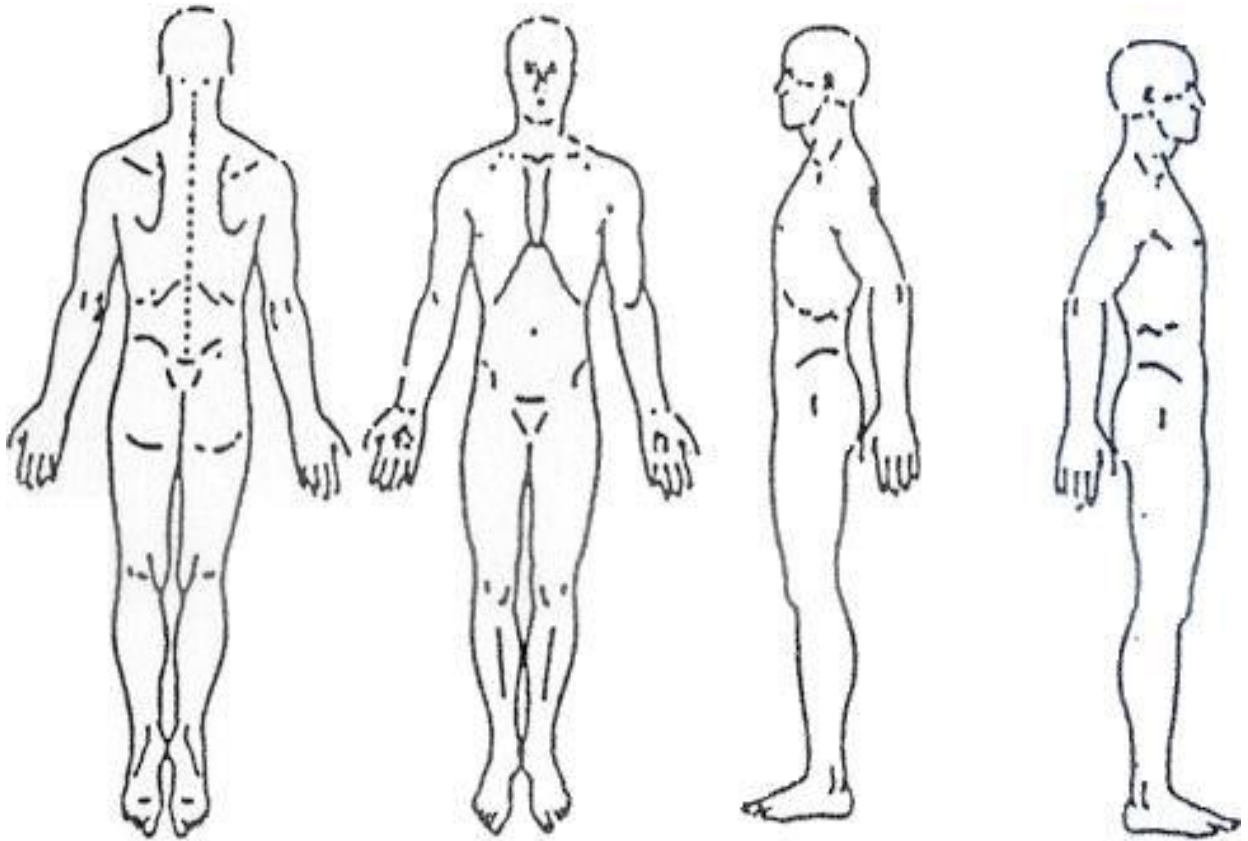
GENTO-URINARY

- | | | |
|---|---|---|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Decrease in Urine | <input type="checkbox"/> Kidney sores |
| <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Waking up to Urinate |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Impotency/ Infertility | How often? _____ |
| <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Genital Sores | |

MUSCULOSKELETAL

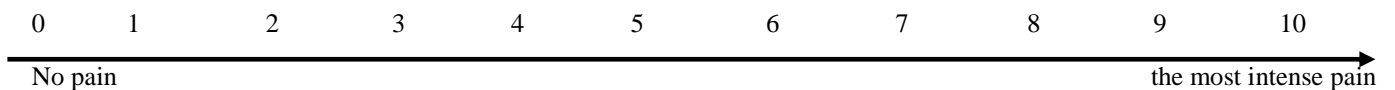
- | | | |
|--|--|---|
| <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Recent Sprains |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Spasms | |
| <input type="checkbox"/> Injuries or Falls | <input type="checkbox"/> Muscular Atrophy | |
| <input type="checkbox"/> General Aches | <input type="checkbox"/> Joint Instability | |

Please circle on the diagram any areas of any type of pain or injury.



Please try to describe the type and quality of the pain _____

Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:



Are there any other internal organ or systemic dysfunctions that we should be aware of? _____

Are there any other problems you would like to discuss? _____

Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

Patient's signature (Parent or Guardian if under 18)

_____/_____/_____
Date