

SCOTTSDALE ACUPUNCTURE & ORIENTAL MEDICINE

This is a confidential health intake to help us determine the best treatment plan for you.
If you have any questions, please ask.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Alt. Phone _____ Email _____

Birth date _____ Height _____ Weight _____ Referred By _____

Major Complaints: _____

Date of Onset: _____ Pain is: Mild Moderate Severe

How long have you had this condition? _____

What makes it better? _____ What makes it worse? _____

Is your condition: Getting better Getting worse Constant

Medication/Drugs/Herbs you are currently taking: _____

List surgeries/operations you have had and the dates: _____

Medical History: (do you have or have you ever had) Arthritis Asthma Anemia Heart Trouble

Cancer Diabetes Epilepsy Stroke Kidney or bladder trouble Gallstones Ulcers

High blood pressure Chronic Fatigue Hepatitis Sudden weight loss/gain

Other: _____

Family History: Has any family member had any of the above? Yes No If yes, which member and what did they have? _____

Energy Level: High (time of day) _____ Low (time of day) _____

Stress: Low Moderate Severe What causes it? _____

Sweating: Night sweats Rarely sweat Excess sweating _____

Circulation: Feeling of Hot Cold What area? _____

Bleed easily Cold Limbs Other: _____

Skin: Dry Itchy Moist/Clammy Burning Changing moles or lumps (cysts/tumors) Boils

Frequent rashes Acne Hair Loss/Thinning Dry Scalp Puffy skin Bruises easily

Cold limbs Other: _____

Scars: (List all scars from accidents or surgeries) _____

Sleep Problems: Trouble falling asleep Trouble staying asleep Restful Excess dreaming

Other: _____ How many hours do you sleep a night _____

Head: Headaches (what area) _____ Dizziness Memory loss Loss of balance

Other: _____

Eyes: Eye Pain Dry eyes Blurred vision Darkness under eyes Other: _____

Ears: Poor hearing Earaches Ear discharge/infections Ringing/buzzing in ears

Nose: Frequent nose bleeds Sinus trouble Frequent colds Other: _____

Throat: Sore Throat Difficulty swallowing Jaw Problems Teeth and gum problems

Chest: Hard to breath Shortness of breath Trouble breathing at night Pain/pressure in chest

Palpitations Persistent cough Coughing blood Coughing phlegm

Blood Pressure: High Low Do not know

Bowels: Diarrhea Constipation Bloody stools Hemorrhoids Gas ____ No. of daily movements

Other: _____

Urination: Color _____ Times per day _____ Frequent Urination Daytime At night

Difficult urination Painful urination Blood in urine Frequent infections

Musculoskeletal: Pain in: Neck Shoulders Between shoulders Arms/hands Hip Knee

Fingers Big toe Upper back Mid back Lower back Bones sore/painful

Loss of grip Swollen knees/elbows Leg cramps at night Weakness in legs

Weak ankles Stiff all over Tingling in feet Muscle spasms/cramps Painful joints

Loss of feeling in hands/feet Bursitis

Other: _____

Neurological: Nervousness Depressed Easily angered Easily irritated Frequent crying

Worry/anxiety Mood swings Memory confusion Poor concentration Suicidal

Tremors Numbness/tingling in limbs Poor coordination Muscle weakness

Seizures Nerve pain Shingles Other: _____

Females: Pregnant Yes No Last monthly period _____ Last PAP test _____

Form of birth control: None Pill Other: _____ Age started menstrual cycle _____

Age stopped _____ Menstrual pain Low backache Irregular Clotting Heavy bleeding

Light scanty bleeding Water retention Mood Changes Miss periods Low/no sex drive

Painful breasts Hot flashes Food cravings Other: _____

Discharges: Yellow Thick White Odor Itching Liquid Other: _____

No. Pregnancies ____ No. Deliveries ____ No. Miscarriages ____ No. Abortions ____ No. Cesareans ____

Operations: Cervix Uterus Ovaries Other: _____

Males: Low sex drive No sex drive Impotence Pain Discharges Pain/burning with urination

Premature ejaculation Prostate trouble Other: _____

Appetite: Excessive appetite Low appetite Appetite changes Feel tired/weak if meal is missed

Excessive thirst Never thirsty Other: _____

Specific food cravings: Yes No If yes, what? _____

Digestion: Stomach gas Lower bowel gas Bloating Heartburn Belching Stomach pain

Nausea Vomiting Bad breath Mouth sores Weight gain Weight loss

Food allergies? Yes No If yes, to what? _____

Nutrition: List your typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

How much water do you consume in a day? _____ Filtered/bottled Tap water

Do you use: Alcohol? Yes No Amount per week _____ Type _____

Tobacco? Yes No Packs per day _____ How many years? _____

Do You:

Eat raw fruits/vegetables each day Yes No

Consume diet drinks? Yes No

Consume juice or milk Yes No

Eat until full Yes No

Go on "crash" diets? Yes No

Eat meat or dairy Yes No

Use table salt or unrefined sea salt? None

Eat when not hungry Yes No

Chew your food thoroughly Yes No

Do regular cleansing diets? Yes No

Patient's Signature _____