Patient Intake Form

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Acupuncture • Asian Bodywork • Massage Therapy

Name:_____ _ _____Date_____
Address:_____zip____
Phone:_____Email_____

Age_____ Birthdate_____

What is your major complaint / What brings you here?_____
When did your symptoms start?_____

List surgeries, what for and when?_____
_____
Major injuries (broken bones, sprains, strains, stitches, etc.)? _____
_____
Major or chronic conditions / diseases?_____
Check any of the following that apply:

___Allergies	___Asthma	___Arthritis	___Headaches
___Indigestion	___Constipation	___Gas/Flatulence	___Gas/Belching
___Loose Stools	___Acne	___Skin Problems	___STDs
___Herpes I or II	___Impotence	___Infertility	___Addictions
___Ulcers	___Dizziness	___Fainting	___Seizures
___Fatigue	___Anxiety	___Insomnia	___Nightmares
___Night Sweats	___Depression	___Varicose Veins	___Psoriasis
___Nausea	___Stress	___Tremors/Shaking	___TMJ Dysfunction
___Hepatitis	___HIV		

Medications (prescription, over-the-counter, or supplements)?_____
_____

What other physicians / practitioners are you currently seeing?_____

Do you smoke?_____ How much per day?_____
How much alcohol do you consume weekly?_____
Do you drink coffee?_____ How much per day?_____

Do you wear contacts?_____

What is your occupation/How do you spend your days?_____

Do you crave any foods/drinks?_____
Describe your daily fluid intake (how much & what kind)?_____
Are you on a special diet now (describe)?_____

Do you tend toward being hot or cold / fever or chills?_____
Do you often have cold hands and/or feet?_____

How often do you have bowel movements?_____
Do you have a tendency toward contipation/diarrhea, hard/soft stools?_____
How often do you urinate?_____Color?_____

Describe your energy level?_____
How do you sleep (quality and how much)?_____

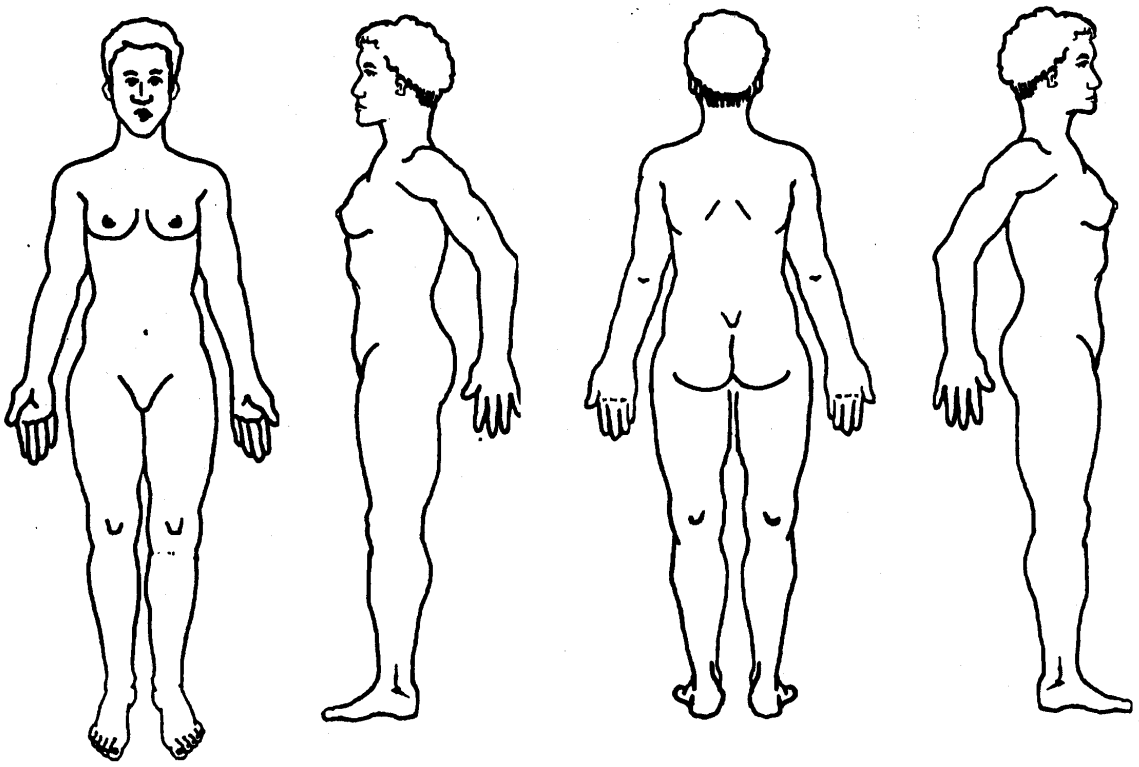
Describe your stress level?_____
What are your most common emotions (anger, sadness, joy, worry, etc.)?_____

Do you exercise?_____Type and frequency?_____

Could you be pregnant?_____
Where are you in your menstrual cycle?_____Light or heavy flow?_____Pain?_____
Date of last period?_____ Age Started?_____ Form of birth control?_____
Number of: pregnancies___ deliveries___ miscarriages___ abortions___ Cesareans___
Are you in menopause?_____

Identify CURRENT symptomatic areas in your body in the figures below:

Circle areas of **PAIN**.
Place an "X" over areas of **Stiffness**.
Draw zig zag lines over areas of **Numbness** or **Tingling**.
Mark **scars, bruises** or **open wounds**.



Additional comments:_____
_____
_____

I have stated all medical information accurately, and will update the therapist of any changes in my condition. I understand that the therapies offered are no substitute for medical care. I agree not to hold the therapist responsible in any way for any problems that might arise.

Signature:_____
Therapist:_____