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Acupuncture
Rolfing
Physical Therapy

Patient Intake Form

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 questions, please ask. Thank you.

Full name ______________________ Sex ☐ F ☐ M Date ______________________

Date of birth ______________________ Age __________ Occupation ______________________

Address ______________________ City ______________ State __________ ZIP ______________

Main phone number ______________________ Other phone number ______________________

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

Relationship status ____________ Children ______ Family physician ______________ Chiropractor ______________

Emergency contact name ______________________ Phone number ______________________

How did you find out about us? ☐ Friends/relatives (Name) ______________________

☐ Direct mail ☐ Location ☐ Website ☐ Yellow pages ☐ Periodicals ☐ Other ______________

Main problem(s)

What is/are your main problem(s)? ______________________

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 your 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 (Please include the month/year when the event occurred or when the diagnosis was made)

Surgeries: ______________________ Hospitalization: ______________________

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

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

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type?)			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		

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 Data

Height ___ Weight now ___ Weight one year ago ___ Weight maximum ___ @Year ___

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 Water? ___ glasses/day

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

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):

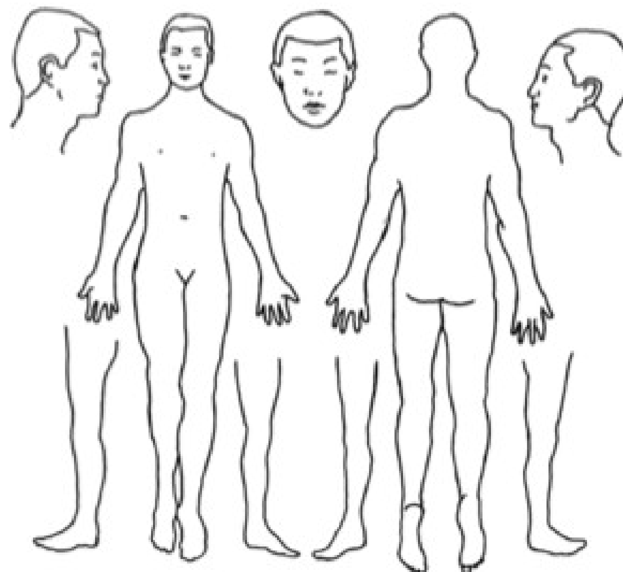
Morning ___

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 ☐ Fevers ☐ Chills

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

☐ 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

☐ Loss of hair ☐ Purpura ☐ Change in hair or skin texture ☐ Other _________

Musculoskeletal

☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in muscles ☐ Tremors

☐ Cold hands/feet ☐ Difficulty walking ☐ Swelling of hands/feet ☐ Spinal curvature ☐ Back pain

☐ Hernia ☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness

☐ Neck pain ☐ Shoulder pain ☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain

☐ Joint sprain ☐ Other _________

Head, eyes, ears, nose, and throat

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens ☐ Eye strain

☐ Eye pain ☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts

☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Sore throat

☐ Spots in front of eyes ☐ Sinus problems ☐ Nose bleeding ☐ Grinding teeth ☐ Teeth problems

☐ Facial pain ☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other ________

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting

☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other ________

Respiratory

☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing ☐ Bronchitis

☐ Pneumonia ☐ Chest pain ☐ Production of phlegm (what color) __________

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas

☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath

☐ Rectal pain ☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Gallbladder problems ☐ Parasites

☐ Chronic laxative use

Bowel movements: Frequency _____________ Color __________________ Odor __________________ Texture _________

Neuro-psychological

☐ Loss of balance ☐ Lack of coordination ☐ Concussion ☐ Depression ☐ Anxiety

☐ Stress ☐ Bad temper ☐ Bi-polar

Genital-urinary

☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate ☐ Kidney stones

☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection

☐ Genital pain ☐ Genital itching ☐ Genital rashes ☐ STD ☐ Other ________

Female

☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Fibroids

☐ Vaginal/genital discharge ☐ Ovarian cysts ☐ Irregular periods ☐ Clots

☐ Pain/cramps prior to/during periods ☐ Breast tenderness ☐ Breast lumps ☐ Hot flashes

☐ Moodiness related to periods ☐ Fertility problems

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-sections _____ 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 ☐ Fertility problems ☐ Erectile dysfunction ☐ Ejaculation problems ☐ Discharge

☐ Frequent seminal emission ☐ Painful/swollen testicles ☐ Other ________

I have completed this form correctly to the best of my knowledge.

Signature: ____ ☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Are there any other health issues you want to discuss with us?

Signature Date