Fiery Sage Healing

ACUPUNCTURE INTAKE FORM

GENERAL INFORMATION

Name: ______________________ Date of Birth: ______________ Date: ____________

Address: ____

City: ______________________ State: ______________ Zip: ____________

Occupation: ______________________ Cell: ______________ Home: ____________

E-mail: ______________________ Emergency Contact: ______________________

FAMILY HISTORY (cancer, disease, illness, etc.)

______________________________ ______________________________

______________________________ ______________________________

OPERATIONS OR ILLNESSES

Date:	Illness or operation:	Date:	Illness or operation:

MEDICATIONS

______________________________ ______________________________

______________________________ ______________________________

MEDICAL HISTORY

Chief Complaint(s): ______________________________

____

____

Cause or how it started: ______________________________

Is your condition due to an accident or an illness? ______________

Have you ever had this condition before? ☐ YES ☐ NO ____________

Have you received treatment for this condition before? ☐ YES ☐ NO ______

If you received treatment, when, by whom, and what was the diagnosis? ______

____

____

What were the results of the treatment? ______________________________

____

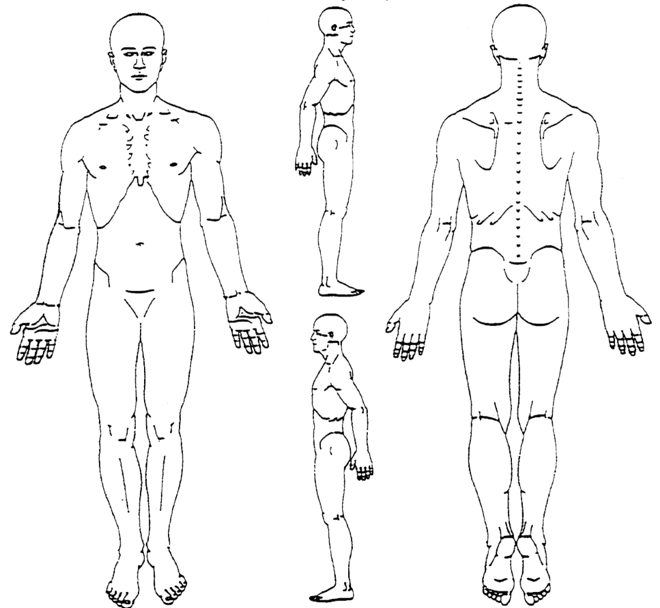
What makes your condition better? ______________________________

____

What makes your condition worse? ______________________________

____

Please indicate where your pain is located



Additional Comments: ____

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ACUPUNCTURE INTAKE FORM

Please read carefully the symptoms below. Check any and all that apply: ○ = past ☐ = present

Eye, Ear, Nose, and Throat
○ ☐ Decreased Hearing
○ ☐ Ringing in Ear
○ ☐ Ear Infections - Frequent
○ ☐ Dizzy Spells
○ ☐ Sensitive to Light
○ ☐ Eye Twitch
○ ☐ Eye Dryness
○ ☐ Failing Vision
○ ☐ Double or Blurred Vision
○ ☐ Eye Pain
○ ☐ Eye Infections - Frequent
○ ☐ Nose Bleeds - Recurrent
○ ☐ Sinus Trouble
○ ☐ Sore Throats - Frequent
○ ☐ Dry Mouth
○ ☐ Lump in Throat
○ ☐ Mouth/ Tongue Sores
○ ☐ Teeth Problems
○ ☐ Grind Teeth
○ ☐ Hayfever / Allergies
○ ☐ Hoarseness - Prolonged

Respiratory
○ ☐ Pneumonia / Pleurisy
○ ☐ Bronchitis / Chronic Cough
○ ☐ Asthma / Wheezing
○ ☐ Shortness of Breath:
On Exertion ☐ Lying Flat ☐
○ ☐ Difficulty Inhaling
○ ☐ Sigh Often
○ ☐ Cough
○ ☐ Cough with Phlegm
○ ☐ Cough with Blood

Circulatory
○ ☐ Heart Problems
○ ☐ Chest Pain
○ ☐ Convulsions / Seizures
○ ☐ Stroke
○ ☐ High Blood Pressure
○ ☐ Low Blood Pressure
○ ☐ Slow Heart Beat Rate
○ ☐ Irregular Heart Beat
○ ☐ Heart Murmur
○ ☐ Palpitations
○ ☐ Irregular Pulse
○ ☐ Ankle Swelling
○ ☐ Facial Swelling
○ ☐ Hand Swelling
○ ☐ Fainting Spells
○ ☐ Numbness/ Tingling
○ ☐ Leg Pain when Walking
○ ☐ Varicose Veins / Phlebitis

Digestion
○ ☐ Recent Loss of Appetite
○ ☐ Bitter Taste in Mouth
○ ☐ Nausea / Vomiting
○ ☐ Foul Breath
○ ☐ Constant Hunger
○ ☐ Difficulty Swallowing
○ ☐ Indigestion or Heartburn
○ ☐ Persistent Nausea / Vomiting
○ ☐ Peptic Ulcers
○ ☐ Abdominal Pain - Chronic
○ ☐ Hemorrhoids
○ ☐ Gall Bladder Trouble
○ ☐ Jaundice / Hepatitis
○ ☐ Hernia

Stool
○ ☐ Change in Bowel Habits
○ ☐ Diarrhea ○ ☐ Constipation
○ ☐ Colon Problems
○ ☐ Diverticulosis
○ ☐ Bloody or Tarry Stools
○ ☐ Burning Anus
○ ☐ Pain / Cramping
○ ☐ Undigested Food in Stool
○ ☐ Intestinal Worms

Urination
○ ☐ Urine Infections - Frequent
○ ☐ Burning
○ ☐ Cloudy
○ ☐ Urgent
○ ☐ Strong Smell
○ ☐ Painful Urination
○ ☐ Blood in Urine
○ ☐ Overnight Urination
○ ☐ Incontinence
○ ☐ Decrease in force of Urination
○ ☐ Kidney Stones
○ ☐ Venereal Disease
○ ☐ Urethral Discharge

General Symptoms
○ ☐ Chronic Fatigue
○ ☐ Weight Loss
○ ☐ Anemia
○ ☐ Bruise Easily
○ ☐ Cancer
○ ☐ Diabetes
○ ☐ Thyroid Disease
○ ☐ Tremor / Hands Shaking
○ ☐ Muscle Weakness
○ ☐ Headaches - Frequent
○ ☐ Dizziness
○ ☐ Vertigo

General Symptoms Continued
○ ☐ Sleeping - Difficulty
○ ☐ Night Sweats
○ ☐ Perspire without Exertion
○ ☐ Cold Hands / Feet
○ ☐ Warm Palms / Soles
○ ☐ Hot Flashes
○ ☐ Alternate Chills and Fever

Pain
○ ☐ Arthritis / Rheumatism
○ ☐ Back Pain - Recurrent
○ ☐ Sciatica
○ ☐ Neck Pain
○ ☐ Hand/ Wrists
○ ☐ Hip
○ ☐ Knee
○ ☐ Foot/ Ankle
○ ☐ Muscle Cramp
○ ☐ Bone Fracture / Joint Injury
○ ☐ Gout
○ ☐ Foot Pain
○ ☐ Cold Numb Feet

Skin
○ ☐ Rashes
○ ☐ Hives
○ ☐ Psoriasis / Eczema
○ ☐ Dry Skin
○ ☐ Oily Skin
○ ☐ Itching
○ ☐ Boils
○ ☐ Moles / Warts

Psychological
○ ☐ Nervousness
○ ☐ Depression
○ ☐ Memory Loss
○ ☐ Excessive Moodiness
○ ☐ Phobias
○ ☐ Mental Illness

Disease
○ ☐ Chicken Pox
○ ☐ Polio
○ ☐ Measles / German Measles
○ ☐ Rheumatic
○ ☐ Scarlet Fever
○ ☐ Mumps
○ ☐ Tuberculosis
○ ☐ Hepatitis
○ ☐ Venereal Disease
○ ☐ Herpes
○ ☐ HIV-Positive
○ ☐ AIDS
○ ☐ Other ____________________

Habits
○ ☐ Alcohol ___________ drinks / week
○ ☐ Smoking ____________ cig. / day
○ ☐ Coffee / Tea __________ cups / day
○ ☐ Soft Drinks ___________ cans / day
○ ☐ Recreational Drugs______________

Male - History
○ ☐ Reduced Sex Drive
○ ☐ Seminal Emission
○ ☐ Impotence
○ ☐ Discharge
○ ☐ Genital Pain
○ ☐ Prostate Problems
○ ☐ Pain/Burning during Urination
○ ☐ Dribbling Urine

Female - History
No. of Pregnancies _________________
No. of Live Births ___________________
No. of Miscarriages _________________
Birth Control Method ________________
B.C. Pill Name ______________________
○ ☐ Reduced Sex Drive
○ ☐ Irregular PAP Test
○ ☐ Facial or Excessive Body Hair

Menses
Age of Onset______# Days of Flow______
Age stopped_______
○ ☐ Irregular
○ ☐ Painful
○ ☐ Heavy Flow
○ ☐ Scanty Flow
○ ☐ Dark Color
○ ☐ Light Color
○ ☐ Clotting
○ ☐ Water Retention
○ ☐ Abdominal Bloating
○ ☐ Painful / Tender Breasts
○ ☐ Emotional Changes
○ ☐ Spotting between Periods
○ ☐ Lump in Throat
○ ☐ Constipation
○ ☐ Diarrhea
○ ☐ Chest Tightness
○ ☐ Hormonal Problems
○ ☐ Backache
○ ☐ Sigh Often
○ ☐ Vaginal Discharge
○ ☐ Flushing / Menopause
○ ☐ Other __________________

Allergies ______________________
____
____

Other important information ____
____
____

Patient Signature ____ *Date* ______________________________

(Parent or Guardian if a minor) The above signed has read the disclosed form.