Unity Community Acupuncture

Connecting Mind - Body - Spirit

Patient Intake Form

This medical questionnaire is CONFIDENTIAL. Please take your time and complete the forms honestly. We understand that some of the questions may seem a little odd, however they are important for us to design the best treatment strategy for you.

General Patient Information

Date: _____

Name: _____

Address/City/State/Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____

Email _____

Occupation _____ Employer _____

Emergency Contact Name_____ Contact Phone _____

Relationship to you _____

Primary Care Physician _____ Physician Phone _____

Gender: _____ Birth date ____ /____/____

Height _____ Weight _____

Marital Status: (Circle all that apply) Single Married Divorced Widowed Partnered

Number of Children _____

Who do you live with: (Circle all that apply) Spouse Partner Children Friends Alone Other

Have you had acupuncture before? Yes No With Whom? _____

Who can we thank for referring you? _____

What is/are the primary reason(s) for your visit?

1. _____
2. _____
3. _____

What initiates your symptoms? _____

What makes them better? _____ Worse? _____

Have you sought other treatment for this? _____

If so, what were the results of your other treatments? _____

Personal History

Check any illnesses or conditions you have or have had in the past:

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Antibiotic Use
- ❑ Asthma
- ❑ Bleed Easily
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Infectious Disease
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Mental and/or Emotional Disorders
- ❑ Multiple Sclerosis
- ❑ Night Sweats
- ❑ Pertussis/ Whooping Cough
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Shingles
- ❑ STDs
- ❑ Stroke
- ❑ Thyroid Disorders
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vascular Disease
- ❑ Pacemaker

Other: _____

List any surgeries, serious illnesses, broken bones, hospitalizations, car accidents, etc.:

_____

_____

List any medications or supplements, etc.:

_____

_____

List the Date and Results of last medical test:

Date	Test	Result	Date	Test	Result
	Cholesterol			Pap Smear	
	Hepatitis			Physical	
	HIV Test			PSA (prostate)	
	Mammogram			Thermography	
	High Blood Pressure			Stool	

Have you been immunized for: (Check all that apply)

- ❑ Chicken Pox
- ❑ Diphtheria/Pertussis/Tetanus (DPT)
- ❑ Hepatitis B
- ❑ Human Papillomavirus (HPV)
- ❑ Influenza
- ❑ Measles/Mumps/Rubella (MMR)
- ❑ Tetanus Only
- ❑ Varicella Virus (Shingles)

Please check illnesses that your FAMILY has experience: (Check all that apply)

- ❑ Alcoholism
- ❑ Allergies
- ❑ Bleed Easily
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Mental and/or Emotional Disorders
- ❑ Obesity
- ❑ Stroke

How many times per week do you consume the following:

Caffeine: _____ Tobacco: _____ Recreational Drugs: _____

Water: _____ Alcohol: _____ Soda: _____

Allergies: List any drugs, foods, or other substance you are allergic/sensitive to:

_____

Women

Are you Pregnant? Yes No If so, when are you due? _____

Date of last menses: _____

Number of days between start of menstrual period to start of next menstrual period: _____

Number of days bleeding during average cycle: _____

Pain/where and when: _____

Flow: Heavy Normal Light Flow Color: _____

Do you have clots? If so what color and size: _____

PMS: (Circle all that apply) Irritable Mood Swings Crying Breast Issues

Breast Tenderness/Pain Breast Masses Nipple discharge Fatigue

Age at first menses: _____

Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Vaginal Discharge? Yes No Sometimes

Yeast infections: _____ History Yeast Infections: _____

Menopause: Age at Onset: _____ Hot Flashes: _____ Night Sweats: _____

Libido Level: _____

Male

Prostate Health: Fine Poor Unknown

Sexual Dysfunction: Yes No Sometimes

Circle all that apply: Prostatitis Hernia Testicular Masses Testicular Sensitivity/Pain

Libido Level: _____