



# Acupuncture Intake

This is a confidential questionnaire to help us determine the best possible treatment plan for you.

First Name	Last Name	Date
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Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Contact Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Person Responsible for your account \_\_\_\_\_

Who can we thank for referring you?: \_\_\_\_\_

Sex: \_\_\_M\_\_\_F Height : \_\_\_\_\_ Weight: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_Married\_\_\_Single\_\_\_Divorced\_\_\_Widowed # of Children: \_\_\_\_\_

**Please indicate any significant illnesses you or one of your blood relatives have had:**

Illness	You	Which Relative	Approx. Age	Illness	You	Which Relative	Approx. Age
Cancer	___	_____	___	Diabetes	___	_____	___
High Blood Pressure	___	_____	___	Seizures	___	_____	___
Rheumatic Fever	___	_____	___	Emotional Disorders	___	_____	___
Infectious Diseases	___	_____	___	Tuberculosis	___	_____	___

**Sexually Transmitted Diseases:** \_\_gonorrhea \_\_syphilis \_\_HIV \_\_HPV \_\_Chlamydia Date? \_\_\_\_\_

**Please indicate the use and frequency of the following:**

	Yes	No	Amount		Yes	No	Amount
Coffee/black Tea	___	___	_____	Tobacco	___	___	_____
Water Intake	___	___	_____	Recreational Drugs	___	___	_____
Alcohol	___	___	_____	Soda Pop	___	___	_____

**Please check if any of the following statements are true:**

I am taking coumadin/warfarin \_\_\_\_\_ I have a pacemaker \_\_\_\_\_

I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs) \_\_\_\_\_

I have known allergies \_\_\_\_\_ Please list \_\_\_\_\_

**List any medications or supplements you are currently taking:**

Medicine	Dosage	Reason	How Long	Prescribed By	Last checkup

What is the primary reason for your visit today?

What other forms of treatment have you had?

List any other complaints or health problems you have:

List any allergies, food sensitivities or food cravings that you have:

List any accidents, surgeries, or hospitalizations (include date):

Lab results of X-rays, MRI, CAT Scan, ultrasound:

## For Women

Age of 1<sup>st</sup> period (menarche) \_\_\_\_ Are you pregnant? \_\_\_ Yes \_\_\_ No # of pregnancies \_\_\_\_  
Age of last period (menopause) \_\_\_\_ # of births \_\_\_\_ # of abortions \_\_\_\_ # of miscarriages \_\_\_\_  
Date of last Gyn exam \_\_\_\_ Pap smear results \_\_\_\_ Date of last Mammogram \_\_\_\_  
Date of last Bone Density Scan \_\_\_\_ Results from both \_\_\_\_  
Number of days between periods \_\_\_\_ Number of days of flow \_\_\_\_ Color of flow \_\_\_\_  
Clots? \_\_\_ Average number of tampons/pads you use per day: 1<sup>st</sup> \_\_\_ 2<sup>nd</sup> \_\_\_ 3<sup>rd</sup> \_\_\_ 4<sup>th</sup> \_\_\_ +days \_\_\_  
Have you been diagnosed with: \_\_\_ Fibroids \_\_\_ Fibrocystic Breasts \_\_\_ Endometriosis \_\_\_ Ovarian Cysts \_\_\_ PID

### **Nature of Pain (Check all that Apply; Please indicate before, during, or after menses)**

\_\_\_ Cramping \_\_\_ Stabbing \_\_\_ Discharge \_\_\_ Vaginal Dryness \_\_\_ Headache  
\_\_\_ Burning \_\_\_ Aching \_\_\_ Nausea \_\_\_ Constipation \_\_\_ Diarrhea  
\_\_\_ Dull \_\_\_ Bloating \_\_\_ Swollen Breasts \_\_\_ Mood Swing \_\_\_ Hot Flashes  
\_\_\_ Consistent \_\_\_ Night Sweating \_\_\_ Increased Libido \_\_\_ Decreased Libido

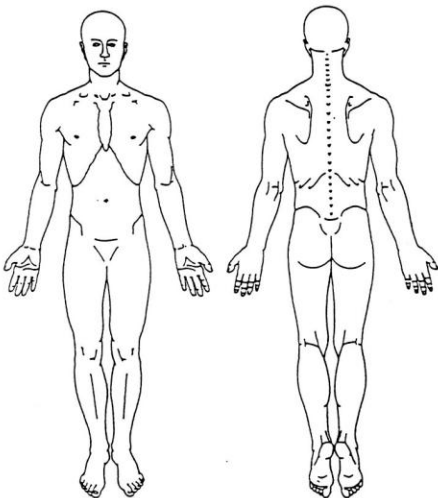
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## For Men

Date of last prostate checkup \_\_\_\_ PSA Results \_\_\_\_ Lab Results \_\_\_\_  
Frequency of urination: Daytime \_\_\_\_ Nighttime \_\_\_\_ Color of Urine: \_\_\_ Clear \_\_\_ Murky Odor: \_\_\_\_  
Symptoms related to prostate (check all that apply):  
\_\_\_ Delayed stream \_\_\_ Dribbling \_\_\_ Incontinence \_\_\_ Retention of Urine  
\_\_\_ Rectal Dysfunction \_\_\_ Increased libido \_\_\_ Decreased libido \_\_\_ Premature ejaculation  
\_\_\_ Impotence \_\_\_ Back pain \_\_\_ Groin Pain \_\_\_ Testicular pain

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**PAIN PATIENTS**, please indicate on the figures below the areas of the body you experience your pain:



### **How would you characterize your pain?:**

dull/achy  sharp/stabbing  burning  tingling  numbness  electrical

### **Describe the onset of your pain (include if it was gradual or acute):**

**Helps Pain (circle):** ice heat rest movement a.m. p.m.  
dampness dry

**Aggravates (circle):** ice heat rest movement a.m. p.m.  
dampness dry

Are there any movements that aggravate the pain?

How does exercise affect your pain?

Do any medications help your pain?

## Symptom Survey

If you experience any of these symptoms place an X for frequently and an O for occasionally.

___ lack of appetite	___ insomnia, diff sleeping	___ cough	___ eye problems
___ excessive appetite	___ heart palpitation	___ shortness of breath	___ Jaundice
___ loose stool	___ cold hands and feet	___ low sense of smell	___ difficulty digesting
___ digestive problems	___ nightmares	___ nasal problems	___ oil
___ vomiting	___ mentally restless	___ skin problems	___ gall stones
___ belching, burping	___ laughing for no reason	___ feeling of claustrophobia	___ light colored stool
___ heartburn/reflux	___ angina pains	___ bronchitis	___ soft or brittle nails
___ feeling retention of food	___ abdominal pain	___ colitis, diverticulitis	___ easily angered
___ in the stomach	___ chest pain	___ constipation	___ difficulty with
___ tendency to become	___ sciatic pain	___ hemorrhoids	___ decisions
___ Obsessive in work &	___ headaches	___ recent use of antibiotics	___ spasms or
___ Relationships	___ pain or cold in genital		___ twitching muscles

___ low back pain	___ fatigue	___ intolerance to weather changes
___ knee problems	___ edema	___ allergies
___ hearing impairment	___ blood in stool	___ hay fever
___ ear ringing	___ black tarry stool	___ dizziness
___ kidney stones	___ bruise easily	___ tendency to faint easily
___ decreased sex drive	___ difficult to stop bleeding	___ high cholesterol levels
___ hair loss	___ asthma	___ sudden weight loss
___ urinary impairment	___ tendency to catch colds easily	

## Acupuncture and Oriental Medicine Consent Form

I the undersigned do hereby authorize Judy Ferguson L.Ac. or Jennifer Aliano L.Ac. to perform the following:

- **Acupuncture:** the insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the body.
- **Electro Acupuncture:** Small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat:** Applying heat generated by an infrared lamp over a specific area of the body.
- **Moxa:** Indirect burning of an herbal compound on acupoints with moxa pole or loose moxa.
- **Cupping:** Cups made of glass are placed on the skin with a vacuum created by heat or suction device.
- **Tui Na:** Traditional Chinese medical massage and manual therapy.
- **Liniments, Oils, Plasters:** Herbal formulas applied topically to the skin.
- **Nutritional Advice:** Includes diet, herbal and supplement recommendations.

I have had an opportunity to ask any questions about these procedures, and I voluntarily consent to having the licensed acupuncturists stated above perform one or more of these actions. I understand there are no guarantees that these procedures will cure or improve my condition. In order for Judy Ferguson and Jennifer Aliano to perform these procedures, I release them from any and all liability that may occur in connection with my treatment.

\_\_\_\_\_  
Signature of patient (or guardian if under 18)

\_\_\_\_\_  
Date