INNER RIVERS ACUPUNCTURE

CONFIDENTIAL MEDICAL INTAKE FORM

Please complete this document as thoroughly as possible. Some of the items may seem unrelated to your current condition, but they may be important in making an accurate diagnosis and formulating an optimal course of treatment.

CONTACT INFORMATION

Name

Today's Date | Date of birth

Mailing Address

City | State | Zip

Email

Primary Phone MOBILE HOME | Secondary Phone MOBILE HOME

How do you prefer to be contacted? (circle top two preferences)
MOBILE PHONE HOME PHONE TEXT EMAIL

Occupation

How did you hear about Inner Rivers Acupuncture?

Name of Guardian (if under 18)

Emergency Contact
NAME PHONE

MAJOR COMPLAINTS (IN ORDER OF SIGNIFICANCE TO YOU)

First Complaint:

Pain Level: 1 2 3 4 5 6 7 8 9 10

Second Complaint:

Pain Level: 1 2 3 4 5 6 7 8 9 10

Third Complaint

Pain Level: 1 2 3 4 5 6 7 8 9 10

HEALTH INFORMATION

Gender | Height | Weight

Primary care provider
NAME TELEPHONE NUMBER

Have you received acupuncture treatment/Chinese medicine before? If so, for what complaint(s)?

Other healthcare professionals seen on a regular basis?

Please list any medications currently taking:

Please list any supplements currently taking:
VITAMINS, MINERALS, HERBS, ETC.

Recent tests:

☐ Physical ☐ Cholesterol ☐ Prostate
☐ HIV/STD ☐ Pap Smear ☐ Mammography
☐ Blood (which?)
☐ Other test(s)

Test results (NOTE BELOW OR ATTACH RESULTS)

FEMININE HEALTH

Regular menstrual cycle:
☐ YES ☐ NO

Length of Cycle:

Average days of flow:

Age of menopause:
IF APPLICABLE

Are you currently pregnant:
☐ YES ☐ NO

Number of pregnancies:

Number of children:

ADDITIONAL HEALTH INFORMATION

List any surgeries or in-patient hospital stays:

Check all that apply to you:

- ☐ Diabetes
- ☐ Migraines
- ☐ Emphysema
- ☐ Polio
- ☐ High Fever
- ☐ Paralysis
- ☐ Stroke
- ☐ Allergies
- ☐ Mumps
- ☐ Jaundice
- ☐ Syphilis
- ☐ Hepatitis
- ☐ HIV
- ☐ Pneumonia
- ☐ Glaucoma
- ☐ Asthma
- ☐ Gonorrhea
- ☐ Measles
- ☐ Chicken Pox
- ☐ Cancer
- ☐ Rheumatic Fever
- ☐ Mononucleosis
- ☐ Vein Condition
- ☐ Meningitis
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Thyroid Disorder
- ☐ Nervous Disorder
- ☐ Bleeding Disorder
- ☐ Multiple Sclerosis
- ☐ Other Spleen Illness
- ☐ Other Kidney Illness
- ☐ Other Liver Illness
- ☐ Other Lung Illness
- ☐ Other Stomach Illness
- ☐ Other Heart Illness

Other:

FAMILY HISTORY HEALTH INFORMATION

Check each of the following that have occurred to any blood relative:

- ☐ Diabetes
- ☐ Obesity
- ☐ Mental Illness
- ☐ Allergies
- ☐ Alcoholism
- ☐ Cancer
- ☐ Stroke
- ☐ Other:
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Nervous Illness
- ☐ Bleeding Disorder
- ☐ Kidney Disease

COMPLAINT DETAILS

PLEASE MARK AREAS OF PAIN BY PUTTING A "**P**" IN THE CORRESPONDING LOCATION. PLEASE MARK SCARS WITH AN "***S***"

Which word(s) best describe your pain:

- ☐ Sharp
- ☐ Fixed
- ☐ Cramping
- ☐ Dull
- ☐ Moving
- ☐ Other:
- ☐ Aching
- ☐ Burning

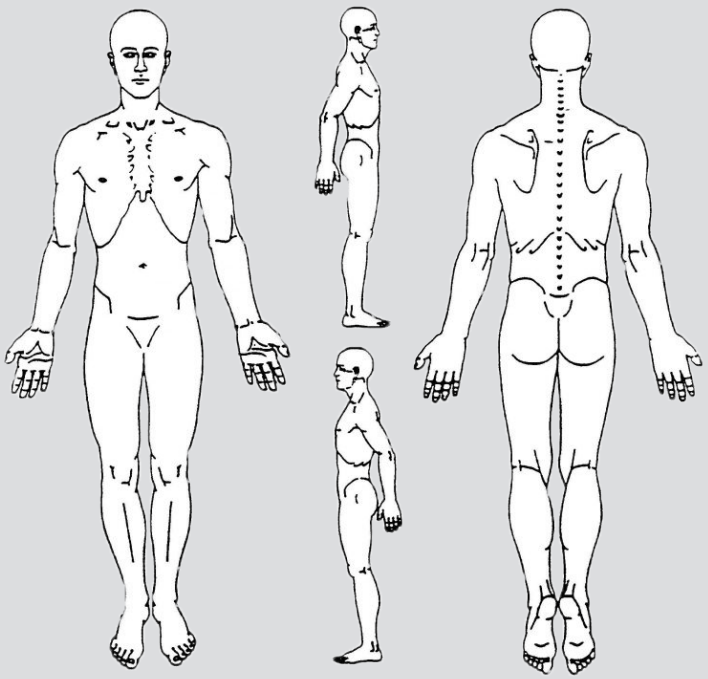
Do any of these **decrease** your pain?

- ☐ Cold
- ☐ Heat
- ☐ Pressure
- ☐ Other:
- ☐ Exercise

Do any of these **increase** your pain?

- ☐ Cold
- ☐ Heat
- ☐ Pressure
- ☐ Other:
- ☐ Exercise

How do you complaints affect your daily activities:



Any other comments:

Patient Signature: _____ Date: _____

Signature: _____ Date: _____

Karen Powers, L. Ac.

INNER RIVERS ACUPUNCTURE

CHINESE MEDICINE INTAKE FORM

Please complete this document as thoroughly as possible. Please mark all current and past symptoms:
C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

OVERALL ENERGY

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Shortness of breath
- ☐ Easily catch colds
- ☐ Difficulty keeping eyes open in daytime
- ☐ Low energy
- ☐ General weakness
- ☐ Feel worse after exercise

DIGESTIVE SYSTEM FUNCTION · SPLEEN, STOMACH, LARGE & SMALL INTESTINE FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Loose stools
- ☐ Diarrhea
- ☐ Mucous in stools
- ☐ Constipation
- ☐ Blood in stools
- ☐ Undigested food in stools
- ☐ Incomplete (*?*)

SPLEEN FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Low appetite
- ☐ Gurgling noise in stomach
- ☐ Pensive
- ☐ Abrupt weight gain
- ☐ Fatigue after eating
- ☐ Over-thinking
- ☐ Worry
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Easily bruised
- ☐ Abdominal gas
- ☐ Hemorrhoids
- ☐ Prolapsed organ(s), which? _____

STOMACH FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Belching
- ☐ Large appetite
- ☐ Heartburn
- ☐ Hiccups
- ☐ Bad breath
- ☐ Acid reflux
- ☐ Stomach pain
- ☐ Canker sores in mouth
- ☐ Diagnosed ulcer
- ☐ Vomiting
- ☐ Burning sensation after eating
- ☐ Bleeding, swollen, or painful gums

HEART FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Palpitations
- ☐ Mental confusion
- ☐ Frequent dreams
- ☐ Sores on tip of the tongue
- ☐ Anxiety
- ☐ Wake unrefreshed
- ☐ Restlessness
- ☐ Chest pain that travels to shoulder
- ☐ Drink caffeine, # of cups/week? _____

OVERALL TEMPERATURE · KIDNEY FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Cold hands
- ☐ Body feels hot
- ☐ Take water to bed
- ☐ Difficulty keeping eyes open in daytime
- ☐ Cold feed
- ☐ Body feels cold
- ☐ Perspire easily
- ☐ Hot flashes any time of day
- ☐ Sweaty hands
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in hands, feet, chest
- ☐ Sweaty feet
- ☐ Thirsty
- ☐ Lack of perspiration

EYES · LIVER FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Nearsighted
- ☐ Farsighted

LUNG FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Dry mouth
- ☐ Swollen hands
- ☐ Cough
- ☐ Dry throat
- ☐ Swollen feet
- ☐ Sinus congestion
- ☐ Dry nose
- ☐ Swollen joints
- ☐ Sneezing
- ☐ Dry skin
- ☐ Overall achy feeling in body
- ☐ Sore throat
- ☐ Nausea
- ☐ Stiff neck
- ☐ Chest congestion
- ☐ Snoring
- ☐ Stiff shoulders
- ☐ Alternating fever & chills
- ☐ Melancholy
- ☐ Nosebleeds
- ☐ Sadness
- ☐ Difficulty breathing
- ☐ Allergies, to what: _____
- ☐ Headache, location: _____
- ☐ Smoke cigarettes, #/day? _____
- ☐ Nasal discharge, color? _____

DAMPNESS TRAPPED IN THE BODY

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ General feeling of heaviness in body
- ☐ Lump in throat
- ☐ Mental heaviness
- ☐ Neck tension
- ☐ High-pitched ringing in ears
- ☐ Mental sluggishness
- ☐ Limited range of motion in neck
- ☐ Convulsions
- ☐ Mental fogginess
- ☐ Shoulder tension
- ☐ Drink alcohols, # drinks/week? _____
- ☐ Gallstones, when? _____
- ☐ Limited range of motion in shoulder
- ☐ Recreational drugs, which & how much? _____
- ☐ Sexually transmitted disease(s), which? _____

BLOOD · LIVER, SPLEEN & HEART FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Dizziness
- ☐ See floating black spots

LIVER & GALLBLADDER FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Alternating diarrhea & constipation
- ☐ Frustration
- ☐ Skin rashes
- ☐ Chest pain
- ☐ Depression
- ☐ Headache at top of head
- ☐ Tight sensation in chest
- ☐ Irritability
- ☐ Tingling sensations
- ☐ Seizures
- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled
- ☐ Muscle cramping
- ☐ Numbness
- ☐ Bitter taste in mouth
- ☐ Muscle spasms
- ☐ Anger easily
- ☐ Frequently unable to adapt to stress, causes of stress? _____

KIDNEY, BLADDER & URINARY FUNCTION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Frequent cavities
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Bladder infections
- ☐ Kidney stones
- ☐ Discharge
- ☐ Low-pitched ringing in ears
- ☐ Difficult urination
- ☐ Painful urination
- ☐ Urgent urination
- ☐ Frequent urination
- ☐ Wake during the night two or more times to urinate

URINATION

C: symptom you're **currently** experiencing -or- **P**: significant symptom you've experienced in the **past**

- ☐ Normal color
- ☐ Dark yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning
- ☐ Painful

Any other symptoms: _____

_____