White Crane
Community Acupuncture

ACUPUNCTURE CLIENT INTAKE FORM

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Name	**E-mail Address**		**Today's Date**
Address	**City**	**State**	**Zip**
Date of Birth (month/date/year)	**Insurance**	**Occupation**	
Preferred Phone	**How you heard about us**		
In Case of Emergency Notify	**Phone**	**Relationship**	
Physician's Name	**Phone**		

MAIN COMPLAINT (symptom, diagnosis, duration of condition, etc):

ALLERGIES (drug, food, chemical/environmental):

DIET: Vegetarian Y/N _____ Meals per Day_____Snacks_____Caffeinated Drinks/Day_____Alcohol Drinks/Week_____

MEDICATIONS Please attach additional page if necessary:

VITAMINS/SUPPLEMENTS/HERBS. Please attach additional page if necessary:

EXERCISE: Days per week_____Length of Workout_____Type of Activity_____

PATIENT NAME _____ ☐ **M** ☐ **F** **DATE** _____

PERSONAL HISTORY

PLEASE CHECK ANY CONDITIONS OR SYMPTOMS YOU HAVE NOW

☐ Arthritis	☐ Liver/Gallbladder Disease	☐ Stroke	☐ Heart Disease
☐ High/Low Blood Pressure	☐ Hypoglycemia/Hyperglycemia	☐ Kidney Disease	☐ Elevated Blood Cholesterol
☐ Cancer	☐ Diabetes	☐ Food Allergies/Intolerance	☐ Diverticulitis/Irritable Bowels
☐ Ulcer	☐ Seizures	☐ Hepatitis	☐ Raynaud's Disease
☐ Chronic Fatigue	☐ Anemia	☐ Thyroid Imbalance	☐ Allergies
☐ Fibromyalgia/Polymyalgia	☐ Lyme Disease	☐ Chronic Pain Condition	☐ Impotence
☐ Gastritis	☐ Asthma	☐ Infertility	☐ Emphysema

FAMILY MEDICAL HISTORY

PLEASE CHECK ANY CONDITION THAT APPLIES TO YOUR IMMEDIATE FAMILY.
PUT AN F (FATHER), M (MOTHER), S (SISTER), B (BROTHER), GM (GRANDMOTHER), GF (GRANDFATHER) NEXT TO CHOICE

☐ Diabetes	☐ Seizures	☐ Heart Disease	☐ Stroke
☐ High Blood Pressure	☐ Allergies	☐ Cancer	☐ Asthma
☐ Other			

PLEASE CHECK IF YOU HAVE HAD ANY OF THESE SYMPTOMS LISTED IN THE LAST THREE MONTHS
(ONLY RELEVANT AREAS ARE NECESSARY):

GENERAL

☐ Poor Appetite	☐ Poor Sleep	☐ Fatigue	☐ Fevers
☐ Chills	☐ Night Sweats	☐ Sweat easily	☐ Tremors
☐ Cravings	☐ Localized Weakness	☐ Poor Balance	☐ Change in Appetite
☐ Bleed/Bruise Easily	☐ Weight Loss/Gain	☐ Peculiar Tastes/Smells	☐ Dental/Gum Problems
☐ Muscle Weakness/Fatigue	☐ Strong Thirst (cold/hot drinks)		

SKIN AND HAIR

☐ Rashes	☐ Ulcerations	☐ Hives/Allergic Dermatitis	☐ Itching
☐ Eczema/Psoriasis	☐ Dandruff	☐ Loss of Hair	☐ Moles
☐ Skin Discolorations	☐ Acne	☐ Change in Skin/Hair Texture	☐ Face Flushing

HEAD, EARS, NOSE, AND THROAT

☐ Dizziness	☐ Difficulty Swallowing	☐ Migraines	☐ Eye Glasses
☐ Eye Strain	☐ Eye Pain	☐ Poor Vision	☐ Night Blindness
☐ Color Blindness	☐ Cataracts	☐ Blurred Vision	☐ Earaches
☐ Ringing in Ears	☐ Poor Hearing	☐ Spots in Front of Eyes	☐ Sinus Problems
☐ Nosebleeds	☐ Recurrent Sore Throats/Colds	☐ Teeth Grinding	☐ Facial Pain
☐ Headaches (where/when)	☐ Dental Problems	☐ Jaw Clicks/Locks	☐ Sores on Lips/Tongue

CARDIOVASCULAR

☐ Chest Pain	☐ Irregular Heartbeat	☐ Palpitations at Rest	☐ Fainting
☐ Cold Hands/Feet	☐ Swelling of Hands/Feet	☐ Blood Clots	☐ Phlebitis
☐ Shortness of Breath	☐ Varicose/Spider Veins	☐ Pressure in Chest	

RESPIRATORY

☐ Cough	☐ Coughing Blood	☐ Asthma	☐ Bronchitis
☐ Pneumonia	☐ Pain with Deep Inhalation	☐ Tight Sensation in Chest	☐ Wheezing
☐ Difficult to Inhale/Exhale	☐ Production of Phlegm		

Any Other Lung Condition:

GASTROINTESTINAL

☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Gas	☐ Belching	☐ Black Stools	☐ Blood in Stools
☐ Indigestion	☐ Bad Breath	☐ Rectal Pain	☐ Hemorrhoids
☐ Bloating/Edema	☐ Chronic Use of Laxatives	☐ Loose Stools (> 2 per day)	☐ Abdominal Pain/Cramps
☐ Changes in Appetite	☐ Acid Reflux	☐ Hernia	

Any Other Problems with Your Stomach/Intestines:

UROGENITAL

- ☐ Pain on Urination
- ☐ Unable to Hold Urine
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Sores on Genitals
- ☐ Decreased Libido
- ☐ Blood in Urine
- ☐ Scanty Flow
- ☐ Urinary Tract Infections
- ☐ Prostatitis
- ☐ Urgent Urination
- ☐ Copious Flow
- ☐ Burning Urination
- ☐ Dribbling after Urination

Do You Wake to Urinate? ☐ Yes ☐ No

What Times: _____

What Color is Your Urine: _____

Any Other Problems with Your Genital or Urinary System?

GYNECOLOGICAL/REPRODUCTIVE

- No. of Pregnancies _____
- No. of Births _____
- No. of Miscarriages _____
- No. of Premature Births _____
- No. of Abortions _____
- Age of First Menses _____
- Date of Last Menses _____
- Date of last PAP/Pelvic _____
- ☐ Painful Menses
- ☐ Irregular Menstruation
- ☐ Ovarian Cysts
- ☐ Vaginal Sores
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Difficult Intercourse
- ☐ Breast Lumps
- ☐ Fibrocystic Breast Tissue
- ☐ Fibroid Tumors
- ☐ Infertility
- ☐ Endometriosis

Are you Pregnant? ☐ Yes ☐ No

Do You Practice Birth Control? ☐ Yes ☐ No

What Type? _____

How Long:

MUSCULOSKELETAL

- ☐ Neck Pain
- ☐ Knee Pain
- ☐ Hip Pain
- ☐ Bursitis
- ☐ Back Pain - lower
- ☐ Shoulder Pain
- ☐ Sprains/Strains
- ☐ Muscle Pain
- ☐ Rotator Cuff
- ☐ Back Pain - middle
- ☐ Hand/Wrist Pain
- ☐ Sciatica
- ☐ Muscle Weakness
- ☐ Back Pain - upper
- ☐ Carpal Tunnel
- ☐ Foot/Ankle Pain
- ☐ Tendonitis

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Lack of Coordination
- ☐ Anxiety/Panic Attacks
- ☐ Loss of Balance
- ☐ Poor Memory
- ☐ Bad Temper/Irritable
- ☐ Vertigo/Dizziness
- ☐ Concussion
- ☐ Easily Susceptible to Stress
- ☐ Areas of Numbness
- ☐ Depression
- ☐ Seasonal Affective Disorder

Have you ever been treated for emotional problems? ☐ Yes ☐ No

Do you have a spiritual life? ☐ Yes ☐ No

Have you every considered or attempted suicide? ☐ Yes ☐ No

Have you ever been treated for substance abuse? ☐ Yes ☐ No

Any other neurological or psychological conditions? If yes, please explain:

Other relevant info or questions?

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PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS