Son Son Acupuncture New Patient Intake Form

Date _____ Referred by _____

Name _____ Date of birth _____

Height _____ Weight _____ Occupation _____

Address _____

E-mail Address _____

Telephone: Home ( ) _____ Work ( ) _____

In emergency notify _____

Relationship _____ Telephone ( ) _____

Physician _____ Telephone ( ) _____

Chief complaint _____

When did this begin? _____

Please describe the condition in detail: _____

_____

What helps it?_____

What makes it worse? _____

What other types of treatments have you tried? _____

_____

Secondary Complaints _____

PERSONAL HEALTH HISTORY

Have you ever been hospitalized? _____ If yes, please describe: _____

_____

Do you smoke? _____ If yes, how much: _____

Do you drink alcoholic beverages? _____ If yes, please describe weekly intake:

_____

Do you drink coffee? _____ If yes, how much per week: _____

Do you take any drugs or medications? _____ Please list: _____

_____

On a scale of 1-10, how is your energy level in general? _____

When is it at its peak? _____ When is it lowest? _____

How would you describe your general emotional state? _____

_____

Please list all herbs, vitamins, and supplements you are taking, and known dosages: _____

_____

_____

Please describe your appetite, including any food cravings: _____

_____

Do you prefer hot or cold drinks? _____ Describe your diet on a typical day:

Breakfast _____

Lunch _____

Dinner _____

Do you engage in any physical activities? _____ Describe type and frequency:

_____

Have you ever had acupuncture? _____ If yes, describe the problem and result:

_____

DISEASES

Please help me provide you with a complete evaluation by filling out the following questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything not asked in the questionnaire that you wish to bring to my attention, please note it in the final section. Thank you.

Please answer all that apply:

General
_ Chills _ Fevers
_ Frequently feel cold
_ Frequently feel hot
_ Sweat easily
_ Night sweats
_ Localized weakness
Where: _____
_ Bleed or bruise easily
_ Peculiar tastes or smells
Describe: _____
_____
_ Strong thirst
_ Thirst, no desire to drink
_ Chronic fatigue
_ Sudden energy drop
Time of day: _____
_ Edema
Where: _____
_ Insomnia
_ Tremors
_ Food cravings
Describe: _____
_____
_ Change in appetite
_ Poor appetite
_ Weight gain
_ Weight loss
_ Frequent colds, coughs

Skin, Hair
_ Rashes
_ Itching
_ Dry skin
_ Eczema
_ Hives
_ Pimples
_ Recent moles
_ Change in skin or hair
_ Loss of hair
_ Dandruff
_ Other skin or hair problems:_____
_____

Head
__ Dizziness
__ Migraines
__ Headaches
When: _____
Where: _____
__ Concussions
__ Facial pain
__ Grinding teeth
__ Teeth problems
__ Jaw clicks
__ Other head or neck problems:_____

Eyes, Ears, Nose, Throat
__ Impaired vision
__ Spots in front of eyes
__ Night blindness
__ Color blindness
__ Cataracts
__ Eye pain
__ Eye dryness
__ Excessive tearing
__ Discharge from eyes
__ Impaired hearing
__ Ringing in ears
__ Earaches
__ Discharge from ear
__ Nose bleeds
__ Sinus congestion
__ Nasal drainage
__ Recurrent sore throats
__ Hoarseness
__ Sores on lips or tongue

Cardiovascular
__ Heart disease
__ High blood pressure
__ Low blood pressure
__ Chest discomfort/pain
__ Heart palpitations
__ Cold hands or feet
__ Swelling of hands
__ Swelling of feet
__ Blood clots
__ Fainting
__ Difficulty in breathing
__ Other heart or blood vessel problems: _____

Respiratory
__ Cough
__ Asthma/wheezing
__ Pain with deep breath
__ Difficulty breathing
when lying down __
Production of phlegm
What color: _____
__ Coughing blood
__ Pneumonia
__ Bronchitis
__ Other lung problems:
_____
___

Gastrointestinal
__ Bad breath
__ Nausea
__ Vomiting
__ Belching
__ Indigestion
__ Ulcers
__ Constant hunger
__ Abdominal pain, cramps
__ Frequency of bowel movements: _____
__ Diarrhea
__ Constipation
__ Laxative use
__ Blood in stools
__ Rectal pain
__ Hemorrhoids
__ Hepatitis
__ Other stomach or intestinal problems:_____
_____

Genitourinary
__ Pain on urination
__ Urgency to urinate
__ Frequent urination
__ Night urination
__ Blood in urine
__ Dark urine
__ Decrease in urine flow
__ Unable to hold urine
__ Dribbling
__ Impotency
__ Sores on genitals
__ Kidney stones
__ Change in sex drive
__ Other genital or urinary system problems:
_____

Pregnancy/Gynecology
_ Number of pregnancies:
_____
_ Number of births: _____
_ Premature births: _____
_ Miscarriages: _____
_ Abortions: _____
_ Age at first menses: _____
_ Onset date of last menses: _____
_ Days in menstrual cycle: _____
_ Usual character:
Heavy _____ Light _____
_ Painful menses
_ Irregular menses
_ Clots
_ Spotting or bleeding between menses
_ Changes in body/psyche prior to menstruation
_ Menopause
Age: _____ Years: _____
_ Vaginal discharge
_ Breast tenderness
_ Breast lumps
_ Nipple discharge
_ Date of last Pap smear:
_____
_ Do you practice birth control?
_____
What type: _____
How long: _____

Musculoskeletal
_ Neck pain
_ Shoulder pain
_ Back pain
_ Elbow pain
_ Hand/wrist pain
_ Hip pain
_ Knee pain
_ Foot/ankle pain
_ Muscle pain
_ Muscle weakness
_ Muscle cramps
_ Arthritis
_ Osteoporosis

Neuropsychological
__ Easily worried
__ Easily startled or frightened
__ Seizures
__ Areas of numbness
__ Weakness
__ Sleep difficulties
__ Disturbing dreams
__ Quick to anger
__ Irritable
__ Loss of control/ violence potential
__ Mental confusion or disorientation
__ Dizziness
__ Lack of coordination
__ Impaired balance
__ Impaired walking
__ Poor memory
__ Depression
__ Susceptible to stress
__ Anxiety
__ Substance abuse
__ Other neurological or
emotional problems:
_____
__ Have you ever been
treated for emotional problems? _____

Other Maladies
__ Allergies
List: _____
__ Cancer
__ Diabetes
__ Thyroid disease
__ HIV/AID

Please note here any other problems you would like to discuss:
_____
_____
_____
_____
_____

Informed Consent for Treatment and Care:

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by Sonya Rosenbrock representing Son Son Acupuncture, on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible).

I understand that there are minor risks associated with acupuncture treatment, including, but not limited to, slight bleeding and/or bruising of the skin, minor burns from moxibustion, the possibility of puncturing organs in the abdomen or chest. I understand acupuncture treatments involve the use of needles and may include other modalities such as acupressure, moxibustion, cupping, gua sha, tui na (Chinese massage) and/or electric stimulation. I understand that the risk of infection is negligible when using single use, disposable needles.

I understand that sometimes articles of clothing will be required to be removed for the access of particular acupuncture points.

Acupuncture may affect people on all levels including physical, mental, emotional and spiritual because it works with the whole body to create balance. The duration of the treatment varies from person to person depending on their specific illness and constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness of treatment after a specific treatment or series of treatments. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patients name_____

Patient's Signature_____ Date:_____