# Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

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|---|---|---|---|
| Full name | | Sex □ F □ M | Date |
| Date of birth | Age | Occupation | |
| Main phone # | | Other phone # | |
| E-mail address | | Allow email contact? □ Yes □ No | |
| Emergency contact & phone # | | Marital status | # of children |
| Address: Street | | City | State Zip |
| Family physician | | Chiropractor | |
| Do you have health insurance? □ Yes □ No | | If yes, name of insurance company | |
| Does your insurance cover acupuncture? □ Yes □ No □ ? | | Who is your employer? | |
| How did you find out about Ashley Simmons, LAc? □ *Friends/Relatives(name)*_____ □ *Direct mail* □ *Location or walk by* □ *Website* □ *Referred by*_____ □ *Other (please specify)* | | | |

**Main problem(s)**: _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____
Remarks and additional information:

## Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

**Surgeries: _____Hospitalization: _____**

**Significant trauma:** (auto accidents, sports injuries, etc) _____

**Allergies:** (drugs, chemicals, foods, environmental):_____

| Diagnosis | Self | Family | Diagnosis | Self | Family | Diagnosis | Self | Family |
|---|---|---|---|---|---|---|---|---|
| Cancer (what type) | | | Breathing problems | | | Tuberculosis | | |
| Diabetes | | | Heart disease | | | High cholesterol | | |
| Hepatitis | | | Digestive disorders | | | High blood pressure | | |
| Thyroid disease | | | Venereal disease | | | Emotional disorders | | |
| Seizures | | | Alcoholism | | | Anemia | | |
| Arthritis | | | Depression or anxiety | | | Other | | |

**Medicines** taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

**Occupation** : _____ Do you usually work □indoors □outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

**Personal** Height_____ Weight now_____ Weight one year ago_____

Weight maximum _____@Year _____

**Habits** Do you smoke ? □ Yes □ No What? _____ How many per day?_____ Since when?_____

Please describe any use of drugs for non-medical purposes:_____

Do you exercise regularly □ Yes □ No Please describe your exercise program: _____

How many hours do you sleep in general? _____ What time do you usually go to bed? _____

**Diet** How much coffee do you drink? _____cups/day Colas _____number/day Tea _____ cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? □ Yes □ No □ Yes, but not so strict Do you eat a lot of spicy food? □ Yes □ No

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

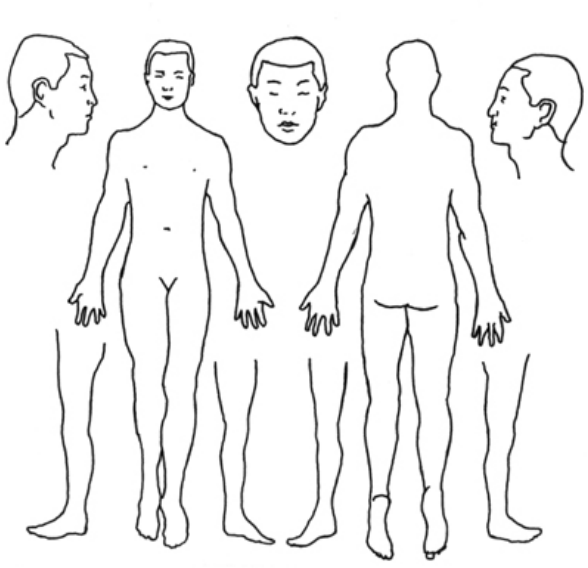
Morning _____

Afternoon _____

Evening _____

Snacks_____

**Indicate painful or distressed areas:**



**Please check if you have or have had (in the last three months) any of the following diseases or conditions.**

**General** □ Poor appetite □ Poor sleep □ Fatigue □ Fevers □ Chills

□ Night sweats □ Sweat easily □ Tremors □ Cravings □ Change in appetite

□ Poor balance □ Bleed or bruise easily □ Localized weakness □ Weight loss □ Weight gain

□ Peculiar tastes □ Desire hot food □ Desire cold food □ Strong thirst (cold or hot drinks)

□ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

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**Skin & hair** □ Rashes □ Ulcerations □ Hives □ Itching □ Eczema

□ Pimples □ Acne □ Dandruff □ Dry skin □ Recent moles □ Loss of hair

□ Purpura □ Change in hair or skin texture □ Other?

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**Musculoskeletal** □ Joint disorders □ Muscle weakness □ Pain/soreness in the muscles □ Tremors

□ Cold hands/feet □ Difficulty walking □ Swelling of hands/feet □ Spinal curvature □ Back pain □ Hernia

□ Numbness □ Tingling □ Paralysis □ Neck tightness □ Neck pain □ Shoulder pain

□ Hand/wrist pain □ Hip pain □ Knee pain □ Joint Sprain □ Other?

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**Head, eyes, ears, nose, and throat** □ Dizziness □ Concussions □ Migraines □ Glasses/lens

□ Eye strain □ Eye pain □ Color blindness □ Night blindness □ Poor vision □ Cataracts

□ Blurry vision □ Earaches □ Ringing in ears □ Poor hearing □ Spots in front of eyes

□ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain

□ Jaw clicks □ Sores on lips/tongue □ Difficulty swallowing □ Other?

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**Cardiovascular** □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting

□ Phlebitis □ Irregular heartbeat □ Rapid heartbeat □ Varicose veins □ Other?

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**Respiratory** □ Cough □ Coughing blood □ Wheezing □ Difficulty breathing

□ Bronchitis □ Pneumonia □ Chest pain □ Production of phlegm – What color? _____

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**Gastrointestinal** □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas

□ Belching □ Black stools □ Blood in stools □ Indigestion □ Bad breath □ Rectal pain

□ Hemorrhoids □ Abdominal pain/cramps □ Gallbladder problems □ Parasites □ Chronic laxative use

Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

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**Neuro-psychological** □ Loss of balance □ Lack of coordination □ Concussion

□ Depression □ Anxiety □ Stress □ Bad temper □ Bi-polar

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**Genito-urinary** □ Painful urination □ Frequent urination □ Blood in urine □ Urgency to urinate

□ Kidney stones □ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infections

□ Genital pain □ Genital itching □Genital rashes □ STD □ Other?

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**Female** □ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Vaginal/genital discharge

□ Fibroids □ Ovarian cysts □ Irregular periods □ Clots □ Pain/cramps prior/during periods

□ Breast tenderness □ Breast Lumps □ Fertility Problems □ Hot flashes □ Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? □ Yes □ No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

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**Male** □ Prostate problems □ Discharge □ Erectile dysfunction □ Ejaculation problems

□ Frequent seminal emission □ Fertility problems □ Painful/swollen testicles □ Other

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I have completed this form correctly to the best of my knowledge.

**Signature:** □ Adult Patient □ Parent or Guardian □ Spouse

**Are there any other health issues you want to discuss?**

**Signature** **Date**