INTAKE FORM

Gene Healy, AP, DOM

► Today's Date:

► How did you hear about our office:

PATIENT INFORMATION					
Patient Name				ne Phone()	
Address			Cel	Phone ()	
City	State	State Zip		ail Address	
DOB	Age	Sex: M F	Ma	rital Status M S W D	
Occupation		Emergency contact person:			
	Emergency contact phone number()				
Please list the persons with whom we may inform about your health condition or treatment (Include family, friends and physicians)					
Name				Phone	
Name				Phone	
Name				Phone	
If Minor: Legal Guardian's Name(print)				(signature)	
List any significant traumas, surgeries or other health conditions				Have you had Acupuncture before? Yes No	
·Year: ·Conditions:				Who is or was your regular doctor? Name:	
·Year: ·Conditions:				City: State	
·Year: ·Conditions:				May We contact them? Yes No	
·Year: ·Conditions:				Are you taking any medications? Yes No (Specify)	
Do you have the following condition(s) currently?(Circle)					
Pregnancy Bleeding Disorder Pacemaker Cancer Ostomy Shunts Local Infection Communicable disease Artificial Joint					
How are your dietary habits? Good Fair Poor					
Do you exercise routinely? Yes No					
I certify that the above statements are true					
Print Name: Signa				ature of patient:	

Examination Record

Name:	Age: Male Female Date: / /					
Chief Complaints (What are the chief complaints you would like us to help you with?)						
1						
CIRCLE THE APPROPRIATE RESPONSE:						
Emotion -	Stable Anxious/Fear Worried Depressed Grief Irritable Easy Stressed Exuberant					
Energy	Overall Energy: Low 1 2 3 4 5 6 7 8 9 10 High					
Hot/Cold	Body: Hot Cold Warm Even Hands/Feet: Hot Cold Warm Even					
Thirst	Never Usual Always Prefers drinking liquids: Cold Hot					
Sweat	Normal Spontaneous Extremities Night Neck Up Whole body					
Appetite	Normal Excessive Poor None Craves: Sweet Sour Bitter Salt Spicy					
Digestion	Normal Bloated Gas Hiccup Reflux Nausea Vomiting Stomache					
Stools	Soft Constipation Diarrhea Blood Mucous Incomplete Hemorrhoids Burn/Itch Rectum					
Stool Frequency Urine	less than 1 X day 1-2 X day more than 2 X day					
	Color without vitamins: Clear Light Dark Blood in urine Keydney/Gull Stones Wakes at night					
Urination Flow	Day Time: 1-5 X day 5-10X day more than 10 X day Night Time: 1-2 times more than 2 times					
Genital	Good Scant Incontinent Hesitant Frequent Urgent Pain Burning Night Bedwetting					
Sleep	Libido: Increased Decreased Impotence Premature ejaculation Vaginal: Dryness Discharge					
Neuro	Restful Interrupted Restless Dreams Difficult: falling asleep staying asleep waking up					
Headache	Dizziness Unbalanced Tremors Seizures Spasms Poor Memory Foggy headed Confused					
Eyes	None Front Top Side Back Whole head Band-type Behind Eyes Sinus Pressure Stabbing Normal Dry Itchy Blurred Spots Red Painful Watery Corrected vision: Yes No					
Mouth	<u>Normal</u> Dry Itchy Blurred Spots Red Painful Watery Corrected vision: Yes No Grinding teeth TMJ Facial Pain Gum problem Sores Dry Excess saliva					
Ears						
Nose	Normal Poor hearing Deaf Earache Discharge Pressure Ringing in the Ear: Low pitch High pitch Normal Dry Bleeds Congestion Postnasal drip Sneezing Allergies Difficult breathing Asthma					
Throat						
Heart	Swollen glands Sore Lumps Enlarged thyroid Cough Burning Irritated Palpitations Racing Irregular HTN Fainting Low BP Blood clots Chest: Tightness Pain					
Circulation						
Mucous						
Menses						
	PostmenopausalLast Menstrual Period:CrampsClotsEarlyHeavyScantyAbsent#of day in cycle:#of Days Bleeding:Blood Color:RedDark redBrownLight red					
	#of day in cycle. #of bary's bleeding. Blood color: Ned Dark red Brown Light red #of Pregnancies: #of birth: #of premature birth: #of miscarriages:					
5,						
weigin	Weight Gain/Loss in a year: Ibs					

For Patients with Pain Describe: Heavy Empty Aching Distending Stabbing Moving Burning Gripping Pulling

MARK THE AREA WHERE YOU HAVE PAIN. X = Sharp Pain O = Dull Pain

Pain Scale: Please indicate below

oderate

Pain

Pain

Severe

Pain

Very

Severe Pain

Worst

Possible Pain

EL H

Gala A