INTAKE FORM

Gene Healy, AP, DOM

►**Today's Date:**

►**How did you hear about our office:**

PATIENT INFORMATION			
Patient Name			**Home Phone( )**
Address			**Cell Phone ( )**
City	**State**	**Zip**	**Email Address**
DOB	**Age**	**Sex: M F**	**Marital Status M☐ S☐ W☐ D☐**
Occupation			**Driver's License - State and Number**
			Social Security 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**
If Minor: Legal Guardian's Name(print)	**(signature)**
Emergency Contact - Name	**Emergency Contact - Phone**

List any significant traumas, surgeries or other health conditions

·Year: ·Conditions:

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Have you had Acupuncture before? Yes☐ No☐

Who is or was your regular doctor?
Name:

City: State

May We contact them? Yes☐ No☐

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: **Signature of patient:**

Examination Record

Name: _____ Age: _____ Male ☐ Female ☐ Date: _____ / _____ / _____

Chief Complaints (What are the chief complaints you would like us to help you with?)

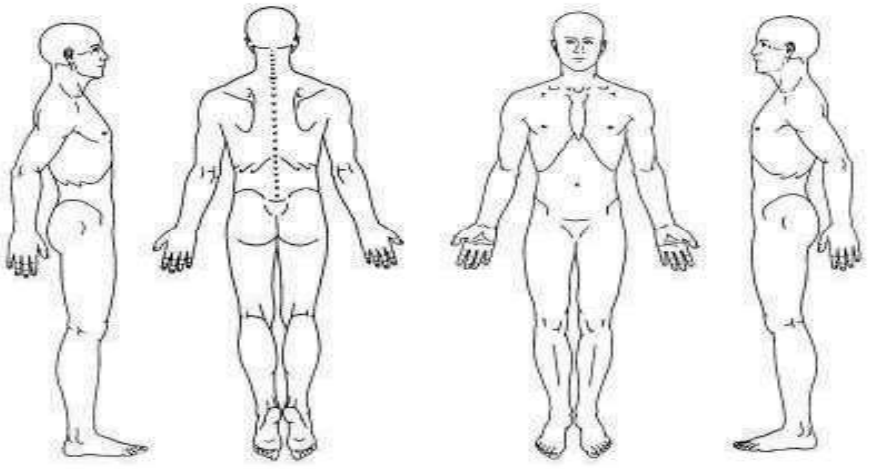
CIRCLE THE APPROPRIATE RESPONSE:

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	less than 1 X day ☐ 1-2 X day ☐ more than 2 X day ☐
Urine	**Color without vitamins:** Clear Light Dark Blood in urine Keydney/Gull Stones Wakes at night
Urine Frequency	**Day Time:** 1-5 X day 5-10X day more than 10 X day **Night Time:** 1-2 times more than 2 times
Urination Flow	Good ☐ Scant ☐ Incontinent ☐ Hesitant ☐ Frequent ☐ Urgent ☐ Pain ☐ Burning ☐ Night Bedwetting ☐
Genital	**Libido:** Increased Decreased Impotence Premature ejaculation **Vaginal:** Dryness Discharge
Sleep	Restful Interrupted Restless Dreams **Difficult:** falling asleep staying asleep waking up
Neuro	Dizziness Unbalanced Tremors Seizures Spasms Poor Memory Foggy headed Confused
Headache	None Front Top Side Back Whole head Band-type Behind Eyes Sinus Pressure Stabbing
Eyes	Normal Dry Itchy Blurred Spots Red Painful Watery **Corrected vision:** Yes No
Mouth	Grinding teeth TMJ Facial Pain Gum problem Sores Dry Excess saliva
Ears	Normal Poor hearing Deaf Earache Discharge Pressure **Ringing in the Ear:** Low pitch High pitch
Nose	Normal Dry Bleeds Congestion Postnasal drip Sneezing Allergies Difficult breathing Asthma
Throat	Swollen glands Sore Lumps Enlarged thyroid Cough Burning Irritated
Heart	Palpitations Racing Irregular HTN Fainting Low BP Blood clots **Chest:** Tightness Pain
Circulation	Normal Numbness Tingling **Loss of Feeling:** Hands Feet Arms Legs Fingers Toes
Mucous	None Thick Thin Profuse Scanty Nonproductive **Color:** yellow green white clear
Menses	Postmenopausal **Last Menstrual Period:** _____ Cramps Clots Early Heavy Scanty Absent
Menses	**#of day in cycle:** _____ **#of Days Bleeding:** _____ **Blood Color:** Red Dark red Brown Light red
Pregnancy	**#of Pregnancies:** _____ **#of birth:** _____ **#of premature birth:** _____ **#of miscarriages:** _____
Weight	**Weight Gain/Loss in a year:** _____ lbs

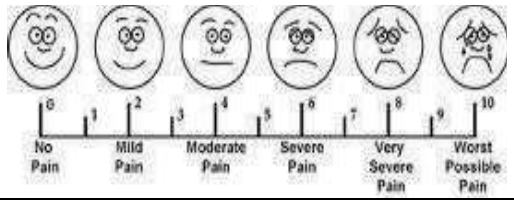
For Patients with Pain Describe: Heavy Empty Aching Distending Stabbing Moving Burning Gripping Pulling

MARK THE AREA WHERE YOU HAVE PAIN.

X = Sharp Pain O = Dull Pain



Pain Scale: ***Please indicate below***



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