VALLEYSPIRIT
COOPERATIVE & WELLNESS CENTER

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Patient Intake Form

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

GENERAL INFORMATION

Name:			Date:	
Street:		Age: Ht.:	Wt.:	
City:		Occupation:	S.S.#:	
State:	Zip:	Home Phone:	Work:	
Date of Birth:		Email:	# of children:	
Family Physician:		Marital Status:		
In Emergency, Notify:				
Referred By:				
Have you been treated by acupuncture before?	Y ☐ N ☐			
Do you have insurance?	Y ☐ N ☐			
Does your insurance cover acupuncture?	Y ☐ N ☐			
Name of Insurance Company:				

MAIN PROBLEM(S) you would like us to help you with: (Please Describe)

How long ago did this problem begin (be specific)?

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

Is your problem work related? If so please explain:

Have you been given a diagnosis for this problem? If so, what?

What kind of treatment/s have you tried?

PAST MEDICAL HISTORY (please include date):

Significant Illnesses:

☐ **Cancer** ☐ **Diabetes** ☐ **Hepatitis** ☐ **High blood pressure** ☐ **Heart disease** ☐ **Rheumatic fever**

☐ **Thyroid disease** ☐ **Seizures** ☐ **Venereal disease** ☐ **Other (please specify)** _____

Surgeries:

Significant trauma (auto accidents, falls, etc.) _____

Birth history: (prolonged labor, forceps delivery, etc.) _____

Allergies: (drugs, chemicals, foods) _____

FAMILY MEDICAL HISTORY (please include date):

Family Medical History:

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Asthma ☐ Allergies ☐ Heart disease

☐ Seizures ☐ Alcoholism ☐ Miscarriage ☐ Other (please specify) _____

OCCUPATION:

List Here: _____

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

Do you have a regular exercise program? Please describe: _____

MEDICINES (taken within last two months - include vitamins, over-the-counter drugs, herbs, etc.):

What Type of Medicines: _____

Are you or have you ever been on a restricted diet? If so what kind? _____

Please describe your average daily diet:

MORNING AFTERNOON EVENING

_____

Do you smoke cigarettes? Y ☐ N ☐ If yes, how many per day? _____

How much coffee, tea, or cola do you drink per week? _____

How much alcohol do you drink per week? _____

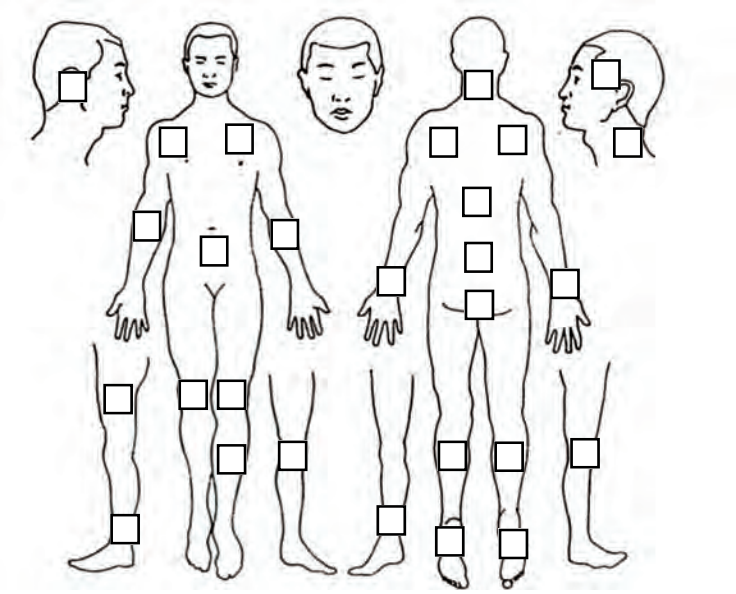
Please describe any use of drugs for non-medical purposes: _____

INDICATE PAINFUL OR DISTRESSED AREAS:

Level of Pain

1 ☐
2 ☐
3 ☐
4 ☐
5 ☐
6 ☐
7 ☐
8 ☐
9 ☐
10 ☐

List Here: _____



Level of Joy

1 ☐
2 ☐
3 ☐
4 ☐
5 ☐
6 ☐
7 ☐
8 ☐
9 ☐
10 ☐

PLEASE CHECK IF YOU HAVE HAD (in the last three months):

Significant Illnesses:

- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed of bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold or hot drinks)
- ☐ Sudden energy drop
  What time of day? _____
- ☐ Desire hot food
- ☐ Desire cold food
- ☐ Poor sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Weight loss
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain

Favorite time of year? _____ Favorite & Worst time of year? _____

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Purpura

Any other hair or skin problems? _____

Head, Eyes, Ears, Nose & Throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue

Headaches (where & when)? _____

Any other head or neck problems? _____

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty in breathing

Any other heart or blood vessel problems? _____

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm
  What color? _____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath

Any other lung problems? _____

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Parasites
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids

Bowel Movement Activity?

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

Any other Gastrointestinal problems? _____

PLEASE CHECK IF YOU HAVE HAD (in the last three months):

Genito-Urinary

- ☐ Pain or urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals

Do you wake up to urinate? Y ☐ N ☐ How often? _____

Any particular color to your urine? Y ☐ N ☐ What color? _____

Any other problems with your genital or urinary system?

Male

- ☐ Prostate
- ☐ Fertility problems
- ☐ Painful / swollen testicles
- ☐ Discharge
- ☐ Ejaculation problems
- ☐ Erectile Dysfunction (E.D.)

Female - Pregnancy & Gynecology

_____ Number of pregnancies _____ Premature births

_____ Number of births _____ Cesareans

_____ Miscarriages _____ Difficult pregnancies/births

_____ Abortions

- ☐ Changes in body/psyche prior to menstruation. If so what?
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Endometriosis
- ☐ Breast masses
- ☐ Ovarian cysts
- ☐ Fertility problems
- ☐ Hot-flashes

Date of your last pap smear: _____ Do you practice birth control? Y ☐ N ☐ Any other information _____

_____ What type & for how long? _____

_____ First date of last period

_____ Age of first menses

_____ Duration of periods

- ☐ Unusual character (heavy or light)
- ☐ Painful periods-abdomen or back
- ☐ Clots
- ☐ Irregular periods

Other info: _____

Musculo-skeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand / wrist pain
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot / ankle pains
- ☐ Hip pain
- ☐ Hernia

Any other joint or muscle problems? _____

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

Signature: _____ Date: _____

All of the above information is true to the best of my knowledge