Shannon Considine, M. Ac., L. Ac., Dipl. Ac.

Patient Intake Form

Please help me provide you with a complete evaluation by taking the tiem to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION:

Name: ____________ Sex: ❑ F ❑ M Date: ________ Email: ____________

Address: ____________ City: ____________ State: ______ Zip: ________

Telephone: ________ (Home) ________ (Work) ________ (Mobile)

Date of Birth: ________ Age: ______ Social Security No: ____________

Single: ❑ Married: ❑ Separated: ❑ Divorced: ❑ Widowed: ❑ Partnered: ❑

Education: ____________ Occupation: ____________

Emergency Contact: ____________ Relationship: ____________

Emergency Contact's Telephone: ________ (Home) ________ (Mobile)

Name of Physician*: ____________ Physician's Telephone: ____________

Physician's Address: ____________

Date of Last Physician Appointment: ____________ Date of Last Gynecology Exam: ________ ❑ N/A

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? ❑ Yes ❑ No

*No contact will be made to the physician without your permission.

FAMILY HISTORY — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box(es).

	Self (date)	Mother	Father	Sibling	Spouse	Children
Cancer or Tumors						
Diabetes						
Blood or Bleeding Disorders/Anemia						
Seizures						
High Blood Pressure/Heart Disease						
Allergies						
Stroke						
Drug Abuse						
Depression or Mental Illness						
Deceased (age)						
Hepatitis						
Kidney Disorders						
Thyroid Disorders						
Musculo-Skeletal Disorder						
Blood Transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs) ____________ Coffee/Tea (cups) ____________ Alcohol (drinks per week) ____________

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MEDICAL: If you have evern been hospitalized for a serious medical illness or operation, please write the most recent ones below. (Do not include normal pregnancies.)

YEAR	OPERATION / ILLNESS

MEDICINES:

What prescription drugs are you currently taking: ______________________

For what condition? ______________________

What over-the-counter medications, herbs, or supplements are you currently taking: ______________________

For what condition? ______________________

Please put a "C" if the condition is current or a "P" if you had it in the past.

General

______ Insomnia
______ Dreams/Nightmares
______ Fatigue
______ Poor Memory
______ Strongly Like Cold Drinks
______ Strongly Like Hot Drinks
______ Recent Weight Loss/Gain
______ Chills
______ Fever

Head & Neck

______ Headaches
______ Migraines
______ Stiff Neck
______ Dizziness
______ Fainting
______ Swollen Glands

Ears

______ Ringing
______ Hearing Loss
______ Hearing Aids
______ Infections
______ Earache
______ Vertigo

Eyes

______ Glasses/Contact Lenses
______ Blurred Vision
______ Poor Night Vision
______ Spots or Floaters
______ Eye Inflammation
______ Double Vision
______ Glaucoma
______ Cataracts

Nose, Throat & Mouth

______ Sinus Infection
______ Hay Fever/Allergies
______ Frequent Sore Throat
______ Difficulty Swallowing
______ Mouth & Tongue Ulcers
______ Frequent Colds
______ Nosebleed
______ Dry Nose
______ Nasal Congestion
______ Loss of Voice
______ Thirst
______ Excessive Phlegm
______ TMJ
______ Facial Pain
______ Gum Problems
______ Dry Mouth

Skin

______ Hives
______ Rashes
______ Eczema / Psoriasis
______ Night Sweating
______ Excess Sweating
______ Dry Skin
______ Easily Bruised
______ Changes in Moles, Lumps
______ Itching

Respiratory

______ Difficulty Breathing
______ Difficulty Breathing w/Reclining
______ Wheezing
______ Asthma
______ Chronic Cough
______ Wet Cough
______ Dry Cough
______ Coughing Up Phlegm
______ Coughing Up Blood
______ Shortness of Breath
______ Tight Chest
______ Pneumonia

Male Genital

______ Impotence
______ Premature Ejaculation
______ Nocturnal Emission
______ Pain/Itching of Genitalia
______ Lumps in Testicles

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Cardiovascular

- ______ High Blood Pressure
- ______ Low Blood Pressure
- ______ Chest Pain or Tightness
- ______ Palpitation
- ______ Rapid Heart Beat
- ______ Irregular Heart Beat
- ______ Poor Circulation
- ______ Swollen Ankles
- ______ Phlebitis
- ______ Anemia
- ______ History of Heart Attack

Gastrointestinal

- ______ Nausea
- ______ Indigestion
- ______ Stomach Pain
- ______ Diarrhea
- ______ Constipation
- ______ Poor Appetite
- ______ Excessive Hunger
- ______ Vomiting
- ______ Gas
- ______ Hiccups
- ______ Acid Regurgitation
- ______ Bloating
- ______ Bad Breath
- ______ Laxative Use
- ______ Bloody Stool

Musculoskeletal

- ______ Joint Pain / Disorder
- ______ Sore Muscles
- ______ Weak Muscles
- ______ Difficulty Walking
- ______ Neck / Shoulder Pain
- ______ Upper Back Pain
- ______ Lower Back Pain
- ______ Rib Pain
- ______ Limited Range of Motion
- ______ Other (describe)

____

____

Neurological

- ______ Seizures
- ______ Tremors
- ______ Numbness or Tingling
- ______ Pain (describe)

____

____

- ______ Paralysis
- ______ Poor Coordination
- ______ Other (describe)

____

____

Mental / Emotional

- ______ Depression
- ______ Mood Swings
- ______ Irritability
- ______ Difficulty Relaxing
- ______ Loneliness
- ______ Sensitive
- ______ Shy
- ______ Cry Often
- ______ Worry a Lot
- ______ Compulsive Behaviors
- ______ Difficulty Focusing
- ______ Hopeless Outlook
- ______ Suicidal Thoughts
- ______ Lose Temper
- ______ Frustration

Urinary

- ______ Pain on Urination
- ______ Frequent Urination
- ______ Urgent Urination
- ______ Blood in Urine
- ______ Unable to Hold Urine
- ______ Incomplete Urination
- ______ Bedwetting
- ______ Wake to Urinate
- ______ Increased Libido
- ______ Decreased Libido
- ______ Kidney Stones

Gynecology (Women Only)

- ______ Currently Pregnant
- ______ # of Pregnancies
- ______ Miscarriages
- ______ Abortions
- ______ Menopause
- ______ Hormone Replacement Therapy
- ______ Irregular Periods
- ______ Menstrual Cramps
- ______ Excessive Blood Flow
- ______ Menstrual Blood Clots
- ______ Breast Tenderness
- ______ Abnormal Pap Smear
- ______ Vaginal Infections
- ______ Vaginal Pain / Itching
- ______ Uterine Fibroids
- ______ Endometriosis
- ______ Breast Lumps, Cysts

Infection Screening:

(Check Self and/or Partner)

- ______ HIV Risk ❑ Self ❑ Partner
- ______ TB ❑ Self ❑ Partner
- ______ Hepatitis Risk ❑ Self ❑ Partner
- ______ History of Sexually Transmitted Diseases ❑ Self ❑ Partner
- ______ Gonorrhea ❑ Self ❑ Partner
- ______ Chlamydia ❑ Self ❑ Partner
- ______ Syphillis ❑ Self ❑ Partner
- ______ Genital Warts ❑ Self ❑ Partner
- ______ Herpes ❑ Oral ❑ Genital ❑ Self ❑ Partner

Other Information

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Referred by: ______________________________

Signature: ______________________________ Date: ______________