Acupuncture and Oriental Medicine Intake Form

Note: Information provided on this form is confidential

Today's Date _____/_____/_____
Name ____
Age ________ Gender _____ Date of Birth _____/____/_____
Address ____
City _________________ State _____ Zip __________
Home Phone ____________________ Work Phone____________________
E-Mail Address ______________________________ Cell Phone ____________________
Emergency contact _________________________ Phone ___________________
Relationship ___________________
Primary care physician ___________________________ Phone ____________________
Referred by __________________________
Have you ever been treated with Acupuncture, Chinese Herbs, Bodywork? _________
If yes, what condition and by whom?
____
What is the purpose of your visit? ____
____

How long have you had this condition? ____
Was the onset sudden or gradual? Explain____
____
Symptoms are relieved by ____
Made worse by ____
What medical diagnosis have you received?
____
What other treatments have you received for this condition?
____
____
What other conditions, diagnoses or health concerns do you have?______________________
____
List all medications taken within the last two months (include vitamins, over the counter drugs, herbs, etc.)
____
____
For what conditions are you taking medications?
____
____

Past Medical History

Please check all of these conditions that apply

____ AIDS/HIV ____Cancer ____Lyme's Disease ____Seizures
____Alcoholism ____Diabetes ____Multiple Sclerosis ____Tuberculosis
____Allergies ____Emphysema ____Pacemaker ____Asthma
____Heart Disease ____Polio ____Lymph Nodes removed ____Birth Trauma
____Hepatitis A/B/C ____Rheumatic Fever ____Herpes I / II ____Scarlet Fever
____Epstein Bar Virus ____Mononucleosis ____Cyclo Megalo Virus ____Prosthetics
____Implants

Other____

List all allergies

____
____

Describe any significant injuries, surgeries, or major illnesses, hospitalizations, and dates

____
____

Are you pregnant? _______ If yes, how many months ______ Are you presently trying to get pregnant? ______

Diet and Food

How is your appetite?

____

Do you have any specific food cravings?

____

Describe meals for a typical day

Breakfast

____

Lunch

____

Dinner

____

How often do you eat/drink

Meat ____________
Dairy (milk, cheese, yogurt) ____________
Wheat (wheat containing products) __________
Coffee or Tea (caffeinated) __________
Sugar/Sweets _________
Alcohol __________________

Are you often thirsty? ________ Prefer hot or cold drinks? _________
How many cups/glasses daily? Water: _________ Soda: _________ Coffee/Tea: __________

Which flavors do you crave?

Salty _______ Sour _______ Bitter _______ Spicy _______ Sweet _______

Gastrointestinal (GI) Profile:

Check all that apply
Bloating_______ Heartburn______ Belching ______ Vomiting _____
Blood in feces _______ Ulcers______ Hernia ______ Indigestion_____ Stomach pain______
Hemorrhoids ______
Bowel movements: How often? _______________ Difficult or painful to pass? _____________
Irregular Bowel movements ______ Constipation ______Diarrhea _______ Gas _______
Undigested food in stool _____ Loose stool ______ Hard stools _____ Rectal Itching _____
Laxative use _________________ Other ________________________

Energy and Exercise

What is your energy level?
____
What time of the day is your energy: Highest? _______________ Lowest? ______________
Do you fatigue easily?
____
What type of exercise do you participate in and how often?
____
____

Emotions and Sleep

How do you feel emotionally?
____
____

Do you have (check all that apply)
Panic attacks ____ Depression ____ Anxiety _____ Bad Temper ____ Nervousness ____
Poor memory _____ Fear/Fright _____ Difficulty concentrating ____
Other
____
____
How many hours of sleep do you usually get per night? _______
Difficulty falling asleep?______ Staying asleep _______ Time of night you wake up?________
Do you wake feeling rested? ______ Do you dream alot? ______ Nightmares? _____________
Where in your body do hold stress?
____
How do you relax or reduce stress?
____
How do you feel about your work or profession?
____
How do you feel about your relationship with your spouse or significant other?
____
Do you use recreational drugs? ______________
If yes, what substance(s)?____

Urogenital

How many times per day do you urinate? __________
Color: Pale yellow ______ Dark yellow/orange _____ Odor ______________
(Check all that apply) Difficulty beginning urination _____ Frequent urination ____
Incontinence ____ Pain on urination ____ Blood in urine____
Urinary tract infection _____ Dribbling when sneezing ____
How is your sexual energy? _________________________________
What type of birth control do you use?
____
Do you have infertility? ______ What was determined to be the cause of your infertility
____
Other urinaryconditions
____

Men

(Check all that apply) Prostatitis _____ Impotence _____ Premature ejaculation ____ Penile blood/mucous discharge _______
Other
____

Women

Please indicate current or previous menstrual conditions even if now menopausal
At what age did you start menstruating? ______ Number of days between cycles _____
Number of days of menstrual flow ______
Color of flow ________ (Check all that apply) Irregular menstruation ____ Heavy flow ____
Light flow ____ No flow _____
Clots _______ Vaginal itching/burning _____ Spotting between periods ______
Pain/discomfort before period _____________________
Other
____
Do you have and vaginal discharge? ______ Amount _____ Color ____ Frequency _____
Blood or mucous breast discharge? _____ Amount _____ Frequency _____
PMS symptoms
____
____
Menopausal symptoms
____
____
Number of pregnancies _________ Number of deliveries ________
Number of miscarriages/abortions ________

Muscles, Joints, and Bones

Do you have pain, tenderness, or tightness? ______
If yes, where?

____
____

Quality of pain Sharp ____ Aching ___ Numb ____ Deep ____ Burning ____ Dull ____
Superficial ____ Tingling ____
Is your pain worse or better with heat?_____cold? _____ movement? ______ rest? ________
Is your pain worse in the AM/PM ______
Check all that apply Swollen joints ____ Arthritis/joint pain ____ Tendonitis ____
Rheumatism _____ Bone pain _____ Muscle pain _____ Repetitive strain injury _____
Other____
____

Respiratory, Eyes, Ears, Nose, Throat, and Head

Do you smoke? ______ How many cigarettes per day? ________ How long have you been smoking? _____________Have you ever tried to quit? _____ If yes, how many times? ______
What method of quitting have you used ____
Check all that apply Painful/red eyes ___ Poor vision ___ Seeing spots ___
Frequent colds _____ Chronic runny nose ____ Post nasal drip ____ Chronic cough ____
Coughing up blood _____ Nose bleeds: ____Pain on inhalation _____ Difficulty inhaling ___
Difficulty exhaling ____ Asthma _____ Cold sores ____ Bleeding gums ____
Dry mouth ____ Frequent sore throat ____ Coughing up mucous ____
Color of mucous ____ How much? ____
Frequent headaches/migraines ____ If yes, where on your head are the headaches/migraines?:
__________________________________ Dizziness ______
Describe ____
Ear pain ____ Clogged/Popping ears ____ Ringing in the ears ____
Other
____

Cardiovascular

Blood Pressure ______/________ Do you have a history of high blood pressure? _____
Have you ever been diagnosed with a heart condition? ______ Irregular heart beat ____
Chest pain ____ Palpitations ____ Varicose veins ____ Phlebitis ____
Lymphedema ____ Cold hands and feet _____ Poor circulation _____
Other
____

Skin and Hair

Do you have Dry skin____ Rashes ____ Itching ____ Acne ___ Eczema ___ Hives ___
Hair Loss ___ Premature graying ____
Other
____

Family Medical History (Please list any significant family illness)

Mother

____

____

Father

____

____

Siblings

____

____

Grandparents

____

____

Auto Accident Cases Only

Date of Accident _________________________

Diagnosis __________________________________

Insurance Company ____

Address ____

____

Name of Insurance Adjuster ______________________________________

Contact Phone number ___________________________________

Claim number ____

Note: A letter of protection is required if you are represented by an attorney.

I,____, certify that the information provided on this intake is accurate, and that I will inform Hana Lanin LAc. if there are any changes to this information.

Insurance Information

Kunlun Mountain Healing will bill your insurance carrier if we receive verification of proper coverage. Please complete the insurance information below, as well as the insurance coverage verification information on the back of this form, and attach a front & back copy of your insurance card(s). We do not bill secondary insurance.

I. Patient Name ______________________________ DOB___________________________
Address____
City _______________________________________ State _____________ Zip ____________
Phone Work ___________ Mobile _____________ Home ______________ Email_________

II. Insured's Name (if different)
____
Address____
City _______________________________________ State _____________ Zip ____________
Phone Work _________________ Mobile _________________ Home
____
Insured's Date of Birth ___/___/______ Relationship to patient ______________

III. Name of Insurance Company
____
Claims Address ____
City _______________________________________ State _____________ Zip ____________
Phone: ______________________________ Group or Policy # _________________________
Insurance ID # ______________________________________

Late visit, late cancellation , and no show policy advisory

Please be on time for your visits. In the event you are late, you will only be afforded the remainder of the allotted visit time. You will be billed the cost of that visit.

Twenty-four hours advance notice is required for cancellations or rescheduling of appointments. In the event this requirement is not honored, you will be billed the cost of that visit. No shows will be billed the cost of the visit.

I have read and agree to the above policy
Signature:______________________________ Date:______________