ACUPUNCTURE INTAKE FORM
Richard Morantz, Acupuncturist

IDENTIFICATION DATA

Name______________________________ Date___________________________
Email Address_____________________
Address___________________________ Date of Birth___________ Age___
City and Zip_______________________ Sex M___ F___
Phone (H)_________________________ Height______ Weight________
(W)_________________________ Referred by ____________________
Occupation_______________________ Name of Doctor________________
Date of last physical exam________
In case of emergency notify____
name phone

CHIEF COMPLAINT

Describe your present complaint, injury or illness and give a brief account of its history and development (include previous conventional and alternative treatment):

PERSONAL HEALTH HISTORY

Circle any of the following conditions you currently have, or have had in the past:

AIDs/HIV	High blood pressure	Parasites
Arthritis	High cholesterol	Seizures
Asthma	Kidney disorder	Stomach disorder
Cancer	Liver/Gallbladder	Intestinal disorder
Diabetes	disorder	Stroke
Epilepsy	Low blood pressure	Thyroid disorder
Heart disease	Multiple sclerosis	Other________________
Hepatitis	Pacemaker	______________________

Please list any major surgeries, serious trauma or hospitalizations you have had:

Please circle any of the following that you are currently taking:

Anti-depressants	Cold tablets	Sleeping pills
Anti-anxiety medication	Hay fever tablets	Tranquilizers
Anti-inflammatories	Antacids	Oral contraceptive pills
Blood pressure meds	Aspirin	
Cholesterol medication	Ibuprofin	

List any other over-the-counter or prescription drugs you are currently taking:	List any vitamins, herbs or supplements you are currently taking:	List any medications, herbs, vitamins or supplements which you are allergic to:

What type of exercise do you do? How often?

Do you consider your life to be stressful? What do you do for stress management?

MENSTRUAL AND PREGNANCY HISTORY

Age periods began_____ Are you still having periods?_____ If not, when was your last?______

How long is your monthly cycle?____ How many days does your period last?_____

When was the first day of your last period?_____ Was it normal?_____

Do you have bleeding between periods?________

Date of last Pap smear ____________ Result__________

Are you pregnant?_____ Months ______

Total number of pregnancies _____ Live births _____ Any complications? ______________________

Signature _____________________________________Date _____________________

Please circle current conditions:

HEAD & FACE
Dizziness or vertigo
Fainting
Headaches
Migraines
TMJ
Other_____________

EARS
Earaches
Ringing in ears
Poor hearing
Other_____________

EYES
Eye pain
Red eyes
Itchy eyes
Blurred vision
Poor vision
Visual changes
Poor night vision
Spots in eyes
Eye inflammation
Other____________

NOSE, THROAT & MOUTH
Nose bleeds
Hay fever or allergies
Sinus problems
Excessive phlegm
*Color of phlegm*_________
Sore throat
Hoarseness
Lumps in throat
Enlarged lymph glands
Teeth problems
Grinding teeth
Gum problems
Dry mouth
Excessive saliva
Oral sores
Other________________

SKIN & HAIR
Acne
Rash
Ulcerations
Dryness
Itching
Hair loss
Fungal infections
Changes in moles or lumps
Water retention
Other__________________

RESPIRATORY
Difficulty breathing
when lying down
Asthma/wheezing
Shortness of breath
Cough
*thick or thin?*_______
*any blood?*_________
Frequent colds
Recurring infection
Other ___________________

CARDIOVASCULAR
Palpitations
Chest pain/tightness
Rapid heart beat
Irregular heart beat
Poor circulation
Swelling of ankles
Other_________________

GASTROINTESTINAL
Nausea
Vomiting
Vomiting blood
Indigestion
Stomach pain
Intestinal pain or cramping
Acid regurgitation
Bad breath
Gas
Poor appetite
Heavy appetite
Eating disorder
Bloating
Bowel movement
*frequency*____________
*texture/form*_________
*color*________________
Diarrhea
Constipation
Blood in stool
Mucus in stool
Hemorrhoids
Recent change in weight
Food cravings
Peculiar taste in mouth
Food allergies
Other___________________

GENITO-URINARY
Urinary problems:
painful *bloody*
frequent *urgent*
incomplete
weak stream
unable to hold
need to wake frequently
Increased libido
Decreased libido
Impotence
Kidney stone
Pain or itching of genitalia
Genital lesions or discharge
Other___________________

GYNECOLOGY
Painful periods
Irregular periods
Abnormal bleeding
Bleeding between periods
Menopausal symptoms
Abnormal pap smear
Pelvic inflammatory disease
Pelvic surgery or hysterectomy
Vaginal infection or discharge
Vaginal sores
Breast lumps
Other______________________

NEURO-PSYCHOLOGICAL
Easily stressed
Irritability
Anxiety
Depression
Seeing a therapist
Tremors or tics
Numbness or tingling
Paralysis
Other______________________

MUSCLES AND JOINTS
Joint pain
Limited range of motion
Neck/shoulder pain
Muscle pain
Weak muscles
Carpal tunnel syndrome
Repetitive motion syndrome
Spinal curvature
Spinal problems
Back pain
Sciatica
Osteoporosis
Other____________________

GENERAL
Poor sleep
Heavy sleep
Frequent dreams or nightmares
Poor memory
Fatigue
Strongly like cold drinks
Strongly like hot drinks
Bodily heaviness
Cold hands or feet
Fever
Chills
Night sweats
Sweat easily
Heavy thirst
Bleed or bruise easily
Muscle cramps
Other_________________