Green Lotus
acupuncture clinic

Initial Intake Form

On the following pages you will find a very detailed questionnaire. Please answer these questions as thoughtfully as possible as the information you provide about your lifestyle, habits, and health history will allow me to determine the best treatment approach for you. Chinese medicine is a holistic medicine that tailors each treatment to the individual and many of these questions may appear to be unrelated to your condition, but will provide useful information. All of the information in this questionnaire is STRICTLY CONFIDENTIAL by law. Thank you and I look forward to working with you.

Personal Information

Name ______________________ Date ______________

Address ______________________

City ______________ State ______________ Zip code ______________

Phone *(contact #)* ______________ *(work)* ______________

E-mail ______________ Age ______ Date of Birth ______________

Occupation ______________ Name of Employer/School ______________

Can I add you to my email list in order to share updates, information and wellness tips? ❒ Yes ❒ No

Gender : ❒ Male ❒ Female
Relationships: ❒ Married ❒ Partnership ❒ Single ❒ Separated ❒ Divorced ❒ Widowed
Live with: ❒ Spouse ❒ Partnership ❒ Children ❒ Friends ❒ Alone

Emergency Contact: ______________ Relationship: ______________

Address: ______________________

Phone *(contact #)* ______________ *(work)* ______________

How did you hear about our clinic? ______________________

Insurance Information

Do you have insurance that covers acupuncture? ❒ Yes ❒ No ❒ Unsure

Insurance Company: ______________________

Phone ______________________

Policy/Group# ______________ Identification # ______________

Health History Questionnaire

Name/DOB: ______________________________

Are you currently receiving healthcare? ❒ Yes ❒ No

If yes, where and from whom? ____

What are you most important health concerns that you are seeking treatment for?
List as many as you can in order of importance

____

____

Family History

Are there any health conditions that are known to run in your family? If so, what? ______________________

____

Hospitalizations and Surgery

What hospitalizations and/or surgeries have you had?

Reason: ______________________________ Year : ______________________

Reason: ______________________________ Year : ______________________

X-Rays and Special Studies

X-rays, CAT scans, MRI's or other studies you have had: ______________________________

____

ALLERGIES: Are you now allergic or hypersensitive to any foods, drugs or medications, environmental, chemicals or animals? ❒ Yes ❒ No
If yes, please describe: ______________________________
PACEMAKER: Do you now have an artificial pacemaker? (a medical device to regulate heart beat) ❒ Yes ❒ No
CHRONIC DISEASES: Do you now have any chronic (or long term) diseases? ❒ Yes ❒ No
If yes, please describe: ______________________________
CONTAGIOUS DISEASES: Do you now have any contagious (or infectious) diseases? ❒ Yes ❒ No
If yes, please describe: ______________________________
BLEEDING DISORDERS: Do you now have any kind of bleeding disorder? ❒ Yes ❒ No
If yes, please describe: ______________________________
FEMALE PATIENTS ONLY: Are you pregnant, or could you potentially be pregnant? ❒ Yes ❒ No
If yes, please describe: ______________________________

Current Medications

Please list any prescription medications, over the counter medications, vitamins, or other supplements or herbs you are currently taking *(please list amount, frequency and duration):*

____

____

Height:______________Weight:____________ How long have you been at this weight?____________________
Does it fluctuate much? ____________________ Do you take any weight loss products? ____________________
How would you describe your health as a child? ____
How would you describe your health now? ____
Predominant emotion: ❒Happy/joyful ❒ Sad/Depressed ❒ Easily angered/irritable ❒ Fearful ❒ Anxious/Nervous
Other: ____
Are you receiving therapy for emotional work? ❒ Yes ❒ No ❒ Past

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____

Please list any foods that make you feel bad/aggravate your symptoms: ____________________

____

Habits

Drink coffee? Other caffeine? ❒ Yes ❒ No ❒ Past
How much/often? ____________________
Drink alcoholic beverages: ❒ Yes ❒ No ❒ Past
How much/often? ____________________
Use tobacco? ❒ Yes ❒ No ❒ Past
How much/often? ____________________
Use recreational drugs? ❒ Yes ❒ No ❒ Past
How much/often? ____________________

Do you have a history of abuse? ❒ Yes ❒ No

Any major traumas? ❒ Yes ❒ No

Do you eat three meals a day? ❒ Yes ❒ No

Do you add salt to your food? ❒ Yes ❒ No

Do you enjoy your work? ❒ Yes ❒ No

Are you under a lot of stress? ❒ Yes ❒ No

Have a supportive relationship? ❒ Yes ❒ No

Have a spiritual or religious practice? ❒ Yes ❒ No

Take vacations? ❒ Yes ❒

Do you exercise? ❒ Yes ❒ No

If yes, what kind? ____________________How often? ____________________

How do you feel after exercise? ❒ energized ❒ fatigued ❒ Other? ____________________

Do you sleep well? ❒ Yes ❒ No Number of hours? __________Do you wake rested? ❒ Yes ❒ No

Do you have vivid or disturbing dreams? ❒ Yes ❒ No

What are your main interests and hobbies: ____

Review of Systems

Name/DOB: ____________________

***Y** = current condition; **N** = never; **P** = past condition*

Symptom	Response
Dry or red eyes	❒ Y ❒ N ❒ P
Blurred or unclear vision	❒ Y ❒ N ❒ P
Floaters or spots in vision	❒ Y ❒ N ❒ P
Headaches	❒ Y ❒ N ❒ P
Migraines	❒ Y ❒ N ❒ P
TMD / jaw problems	❒ Y ❒ N ❒ P
Muscle spasms or twitching	❒ Y ❒ N ❒ P
Tension in shoulder or neck	❒ Y ❒ N ❒ P
Pain under ribs or diaphragm	❒ Y ❒ N ❒ P
Chest pain or stuffiness	❒ Y ❒ N ❒ P
Difficult swallowing, laryngitis	❒ Y ❒ N ❒ P
Irritable or short tempered	❒ Y ❒ N ❒ P
Herpes	❒ Y ❒ N ❒ P
Ulcers	❒ Y ❒ N ❒ P
Frequent sighing	❒ Y ❒ N ❒ P
Skin rashes	❒ Y ❒ N ❒ P

Symptom	Response
Poor appetite	❒ Y ❒ N ❒ P
Fatigue after eating	❒ Y ❒ N ❒ P
Abdominal bloating	❒ Y ❒ N ❒ P
General feeling of body heaviness	❒ Y ❒ N ❒ P
Swollen hands or feet	❒ Y ❒ N ❒ P
Prolapsed organs, hemorrhoids	❒ Y ❒ N ❒ P
Bruise easily	❒ Y ❒ N ❒ P
Hard to gain, lose, regulate weight	❒ Y ❒ N ❒ P
Heartburn or acid reflux	❒ Y ❒ N ❒ P
Peculiar taste	❒ Y ❒ N ❒ P
Stomach or abdominal pain	❒ Y ❒ N ❒ P
Frequent belching	❒ Y ❒ N ❒ P
Frequent abdominal gas	❒ Y ❒ N ❒ P
Indigestion, nausea or vomiting	❒ Y ❒ N ❒ P
Excessive hunger	❒ Y ❒ N ❒ P
Excessive thirst	❒ Y ❒ N ❒ P
Bleeding, swollen, painful gums	❒ Y ❒ N ❒ P
Bad breath	❒ Y ❒ N ❒ P
Easily worried, overwhelmed	❒ Y ❒ N ❒ P
Mental sluggishness	❒ Y ❒ N ❒ P

Symptom	Response
Fatigue, tiredness, generally weak	❒ Y ❒ N ❒ P
Sweat easily, spontaneously	❒ Y ❒ N ❒ P
Sweat at night	❒ Y ❒ N ❒ P
Feverish in afternoon	❒ Y ❒ N ❒ P
Facial flushes	❒ Y ❒ N ❒ P
Dizziness or vertigo	❒ Y ❒ N ❒ P
Feel better with exercise	❒ Y ❒ N ❒ P
Feel worse with exercise	❒ Y ❒ N ❒ P
Body feels colder	❒ Y ❒ N ❒ P
Body feels warmer	❒ Y ❒ N ❒ P
Numbness	❒ Y ❒ N ❒ P

Symptom	Response
Frequent colds or flu	❒ Y ❒ N ❒ P
Colds or flu linger for weeks/months	❒ Y ❒ N ❒ P
Dry skin, nose, mouth, or throat	❒ Y ❒ N ❒ P
Asthma/Bronchitis/Allergies	❒ Y ❒ N ❒ P
Cough	❒ Y ❒ N ❒ P
Acne, rashes, eczema	❒ Y ❒ N ❒ P
Shortness of breath with little exertion	❒ Y ❒ N ❒ P
Nasal discharge, congestion	❒ Y ❒ N ❒ P
Nose bleeds	❒ Y ❒ N ❒ P
Frequent sore throats	❒ Y ❒ N ❒ P
Sadness/Grief	❒ Y ❒ N ❒ P

Symptom	Response
Low back pain	❒ Y ❒ N ❒ P
Sore, weak or cold knees	❒ Y ❒ N ❒ P
Puffy or darkness under eyes	❒ Y ❒ N ❒ P
Ringing in ears or poor hearing	❒ Y ❒ N ❒ P
Low motivation/lack of willpower	❒ Y ❒ N ❒ P
Wake more than one time a night to Urinate	❒ Y ❒ N ❒ P
Puffy or swollen ankles or feet	❒ Y ❒ N ❒ P

Review of Systems Continued

***Y** = current condition; **N** = never; **P** = past condition*

Insomnia ❒ Y ❒ N ❒ P
Mouth or tongue sores ❒ Y ❒ N ❒ P
Chest pain ❒ Y ❒ N ❒ P
Poor memory ❒ Y ❒ N ❒ P
Anxiety or nervousness ❒ Y ❒ N ❒ P
Mental confusion or disorientation ❒ Y ❒ N ❒ P

Blood or mucous in stools ❒ Y ❒ N ❒ P
Pain with elimination ❒ Y ❒ N ❒ P
Constipation ❒ Y ❒ N ❒ P
Constipation alternating with diarrhea ❒ Y ❒ N ❒ P
Irritable bowel syndrome ❒ Y ❒ N ❒ P
Undigested food in stools ❒ Y ❒ N ❒ P
Loose stools or diarrhea ❒ Y ❒ N ❒ P
Dry, hard stools ❒ Y ❒ N ❒ P
Difficulty passing stool ❒ Y ❒ N ❒ P

Urgency with urination ❒ Y ❒ N ❒ P
Difficulty urinating ❒ Y ❒ N ❒ P
Painful urination ❒ Y ❒ N ❒ P
Strong smelling urine ❒ Y ❒ N ❒ P
Blood in urine ❒ Y ❒ N ❒ P
Excessive urination ❒ Y ❒ N ❒ P
Frequent urination ❒ Y ❒ N ❒ P
Dribbling or incontinence of urine ❒ Y ❒ N ❒ P

Women Only

Age at first menses ____________________
Age at last menses (if applicable) ____________________
Length of cycle ____________________
Duration of menses (days) ____________________
Pregnancies ____________________
Live births ____________________
Miscarriages ____________________
Abortions ____________________
Date of Last Pap ____________________
Abnormalities ____________________

Are you cycles regular ❒ Y ❒ N ❒ P
Large Clots ❒ Y ❒ N ❒ P
PMS ❒ Y ❒ N ❒ P
Endometriosis ❒ Y ❒ N ❒ P
Uterine Fibroids ❒ Y ❒ N ❒ P
Ovarian Cysts ❒ Y ❒ N ❒ P
Difficulty conceiving ❒ Y ❒ N ❒ P
Vaginal Discharge/infections ❒ Y ❒ N ❒ P
Interstitial Cystitis ❒ Y ❒ N ❒ P
On birth control or hormones ❒ Y ❒ N ❒ P
Menopausal symptoms ❒ Y ❒ N ❒ P

Date of last period ____________________
Flow is: ❒ light ❒ medium ❒ heavy ❒ inconsistent
Color is: ❒ brown ❒ bright red ❒ brick red ❒ red-purple ❒ pale red ❒ watery ❒ thick
Libido is: ❒ low ❒ medium ❒ high

Men Only

Hernias ❒ Y ❒ N ❒ P
Testicular Pain ❒ Y ❒ N ❒ P
Lump or swelling in testicles ❒ Y ❒ N ❒ P
Difficult or loss of erection ❒ Y ❒ N ❒ P
Nocturnal emissions ❒ Y ❒ N ❒ P
Prostate disease ❒ Y ❒ N ❒ P
Infertility ❒ Y ❒ N ❒ P
Other ____________________
Libido is: ❒ low ❒ medium ❒ high

Thank You! I appreciate the time you spent to complete this.

Name/DOB:_______________________

Musculoskeletal

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.

KEY

Please make a slash through this line to indicate your level of pain

XXX Spasm

ZZZ Tenderness

//// Stabbing

⊗⊗ Numbness/Tingling

000 Ache/Pain

↓ or ↑ Radiating Pain

No pain *Worst possible pain*