Community Acupuncture Patient Intake Form

EIGHT ELEMENTS WEST
HEALTH HEALING FITNESS

Today's Date : _____/_____/_____

Name: _____ (Last, First, Middle)

Gender: Male Female Date of Birth: _____/_____/_____ Age: _____ Race/Ethnicity: _____

Marital Status: Single Married Separated Divorced Widowed Living together

Cell Phone # _____ OK to leave message on this number? YES NO

Home Phone # _____ OK to leave message on this number? YES NO

MILITARY HISTORY

Entry date of service: _____/_____/_____ Time in Service: _____yrs _____mo Circle One: Continuous or Broken service

Please list your deployments

Date	Location	Combat Zone? Y or N

CHIEF COMPLAINTS

What is your understanding of why you have been referred here? _____

_____

How long have the issues been present? _____

What provider referred you to our clinic? _____

Have you received acupuncture before? Y__ N__ If yes, when: _____

MEDICAL HISTORY

Please list medications you are currently taking: _____

_____

_____

Please list supplements, herbal remedies, or over-the-counter medications: _____

_____

Please list medical problems or surgeries that you have now or in the past: _____

_____

_____

PLEASE CHECK ALL THAT APPLY:

☐ Do you smoke cigarettes or use other tobacco products? ☐

☐ Do you drink caffeinated beverages? ☐ Do you drink alcoholic beverages?

☐ Have you ever had any problems due to your alcohol use (family, work, legal)?

TBI/blast exposure?	Trouble Sleeping?	Stress Reponses- Do you feel or have experienced the following?
☐ Headache ☐ Constant pain ☐ Pain comes and goes ☐ Nausea/vomit with Headache ☐ Memory loss ☐ Balance problems ☐ Light sensitive ☐ Hearing problems ☐ Vision problems	☐ Avg. hours of sleep? _____ ☐ Trouble staying asleep ☐ Trouble falling asleep ☐ Nightmares ☐ Night sweats ☐ Teeth Grinding ☐ Sleepwalking	☐ Anxiety ☐ Anger ☐ Numbness/Detached ☐ On guard, watchful/jumpy ☐ Panic attacks ☐ Patrol the house ☐ Difficulty Breathing ☐ Palpitations ☐ Re-occurring or intrusive thoughts ☐ Depression ☐ Fatigue
Other Health Information		**PAIN**
☐ Asthma or lung conditions ☐ Sinus problems ☐ Athlete's foot ☐ Abdominal /digestive ☐ Constipation/diarrhea ☐ Hernia ☐ Diabetes ☐ Pregnancy ☐ Rash/fungus	☐ Allergies _____ ☐ Blood clots ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Varicose veins ☐ Circulatory/heart problems ☐ Seizures *Please elaborate any other health concerns:* _____ _____ _____ _____	☐ Jaw pain/TMJ pain ☐ Arthritis/tendonitis ☐ Muscle/bone injuries ☐ Muscle/joint pain ☐ Numbness/tingling ☐ Spinal disorders ☐ Sprain/strain **RATE PAIN 1-10,** 10=highest, _____ When did pain start? _____ What have you done for relief? _____ _____ _____

Please mark in the diagram below any areas where you have pain or discomfort.
P = pain or tenderness **S =** joint or muscle stiffness **N =** numbness or tingling