

Rocky Point Acupuncture

Patient Intake Form

PATIENT INFORMATION

Date _____
Name _____
Address _____
City _____ Postal Code _____
Age _____ Birthdate _____
Occupation _____
How did you hear about us _____

CONTACT INFORMATION

Home phone _____
Work phone _____
Other/cell phone _____
Email _____
Care Card Number _____
Primary physician _____
Physician phone number _____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1- _____
2- _____
3- _____

How is your sleep? _____

List any Allergies (drugs, foods, etc.) _____

List medications or food supplements you are taking.

List serious illnesses, accidents or surgeries.

Check illnesses that have occurred in blood relatives.

- Diabetes High Blood Pressure Stroke
 Cancer Heart Disease Kidney Disease

Check symptoms you have or have had in the last year:

- Depression
- Difficulty in focusing
- Dizziness
- Easily startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/tiredness
- Headaches
- Loss of sleep/poor sleep
- Loss or gain of weight
- Nervousness/irritability
- Overwhelmed by life

Check conditions you have or have had in the past:

- AIDS
- Allergies
- Anemia
- Arthritis
- Bleeding disorders
- Breast lump
- Cancer
- Diabetes
- Hepatitis
- High/Low Blood pressure

How long has it been since you have had a complete medical exam?

Please see other side

HEALTH HISTORY...CONTINUED

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- Tremors or Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms or Hips
- Back Legs
- Feet
- Neck
- Hands
- Shoulders
- Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats ___ night ___ daytime

GENTO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
 - Clots in menses
 - Excessive menstrual flow
 - Extreme menstrual pain
 - Irregular cycle
 - Menopausal symptoms
 - PMS
 - Previous miscarriage
 - Scanty menstrual flow
- Could you be pregnant? _____

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

I Verify that the above information is correct to the best of my knowledge and hereby give my full consent for the treatments required. I will not hold this clinic liable for any claims and hereby declare my understanding of the above. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature _____

Date _____