EAST WIND ACUPUNCTURE

Restoring Health Naturally

NEW PATIENT INTAKE FORM
(CONFIDENTIAL INFORMATION)

FOR CONSULTATION APPOINTMENT

1. Please complete the enclosed medical history forms, and bring them with you to your first appointment.

2. We require a minimum 24 hour notice of cancellation if you are unable to keep your appointment. The initial consultation is a service we provide free of charge to find out if we are able to help you with your current health problems, without cost of obligation. We set aside 2 hours for this appointment and would normally cost $140. There is no treatment at this appointment. To schedule your exam and treatment to follow, please call our office.

FOR EXAM & FIRST TREATMENT APPOINTMENT

1. You should eat food within 6 hours of receiving your treatment. If you have not, a light snack is recommended. It is important that you do not eat a heavy meal or drink alcohol right before your treatment.
2. Depending on the nature of the complaint, needles may be retained for various lengths of time, and additional modalities may need to be used, thus resulting in varying treatment times.
3. It is not always necessary to disrobe. Depending on where the needles are placed, specific article of clothing may need to be removed. It is advisable to wear undergarments since it is not always possible to cover the body completely.
4. For accurate diagnosis, it is important to examine your tongue. If possible, do not brush your tongue the day or your exam and treatment. Additionally, try to avoid coffee, tea, or hard candies within 2 hours of treatment as these will falsely discolor the tongue.
5. Only pre-sterilized, disposable acupuncture needles are used. Needles are not reused.

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HEALTH HISTORY QUESTIONNAIRE
INFORMATION FOR YOUR ACUPUNCTURIST

Important: Complete this document as thoroughly as possible. Some of the question that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

GENERAL PATIENT INFORMATION

Date: _____ Name: (Mr. - Mrs. - Ms.) _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Email: _____

Legal Guardian: (if under 18 years of age) _____

Emergency Contact: (name and phone number) _____

Gender: ___ M ___ F Height: ____ ' ___ " Weight: ____lbs SSN: _____

Driver's License Number: _____ Occupation: _____

Employer: _____ How did you hear about us? _____

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

How do these conditions impair your daily activities? _____

_____

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PATIENT MEDICAL HISTORY

How was your childhood health? _____

Hospital visits/stays: _____

Recent Tests: (please indicate test results and date below)

❒ Physical ❒ Cholesterol ❒ Prostate ❒ Blood (which?) ❒ HIV/STD ❒ Pap Smear ❒ Mammography ❒ Other

Test results and date: _____

Check any that you have had in the past:

❑ Diabetes	❑ Allergies	❑ Glaucoma	❑ Rheumatic Fever
❑ Heart Disease	❑ CVA (stroke)	❑ Vein Condition	❑ Thyroid Disorder
❑ Asthma	❑ Pneumonia	❑ Tuberculosis	❑ Emphysema
❑ Jaundice	❑ Gonorrhea	❑ Mumps	❑ Bleeding Tendency
❑ Syphilis	❑ Measles	❑ Chicken Pox	❑ Nervous Disorder
❑ Meningitis	❑ HIV	❑ Polio	❑ Mononucleosis
❑ Epilepsy	❑ High Fever	❑ Hepatitis	❑ Multiple Sclerosis
❑ Paralysis	❑ Cancer	❑ Migraines	❑ High Blood Pressure
❑ Other Lung Illness	❑ Other Liver Illness	❑ Other Heart Illness	❑ Other Kidney Illness

❑ Other _____

Immunizations: _____

Surgeries: _____

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PATIENT PROFILE

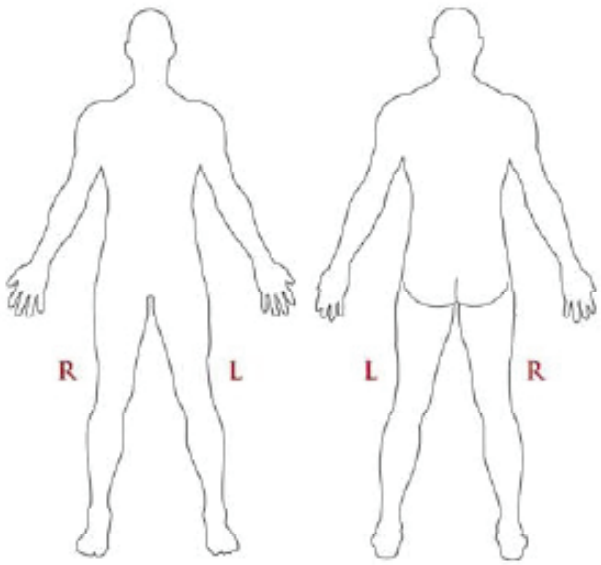
Please clearly mark any areas of pain and any scares (please indicate which of the areas are scars)

Is the pain:

❑ Sharp ❑ Burning ❑ Aching

❑ Cramping ❑ Dull ❑ Moving

❑ Fixed ❑ Other: _____



Do the following improve the pain?

❑ Pressure ❑ Cold ❑ Heat

❑ Exercise ❑ Other: _____

Do the following worsen the pain?

❑ Pressure ❑ Heat

❑ Cold ❑ Other: _____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

OVERALL TEMPERATURE (Kidney Function)

❑ Sweaty feet ❑ Night sweats ❑ Perspire easily

❑ Hot body temperature (sensation) ❑ Heat in the hands, feet, and chest ❑ Lack of perspiration

❑ Cold body temperature (sensation) ❑ Hot flashes any time of the day ❑ Take water to bed

❑ Afternoon flushes ❑ Thirsty ❑ Cold hands and feet

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Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

OVERALL ENERGY (Lung, Kidney function)

- ❑ Shortness of breath
- ❑ Difficulty keeping eyes open in the daytime
- ❑ Feel worse after exercise
- ❑ General weakness
- ❑ Low energy
- ❑ Easily catch colds

OVERALL BLOOD (Liver, Spleen, Heart function)

- ❑ Dizziness
- ❑ See floating black spots

HEART FUNCTION

- ❑ Palpitations
- ❑ Sores on the tip of the tongue
- ❑ Mental confusion
- ❑ Frequent dreams
- ❑ Anxiety
- ❑ Restlessness
- ❑ Chest pain traveling to shoulder
- ❑ Wake unrefreshed
- ❑ Drink coffee (# of cups per week:_____)

LUNG FUNCTION

- ❑ Nasal Discharge (Color: _____)
- ❑ Coughs
- ❑ Dry throat
- ❑ Sneezing
- ❑ Allergies (To what?_____)
- ❑ Nose Bleeds
- ❑ Dry nose
- ❑ Achy feeling
- ❑ Headache (Location: _____)
- ❑ Sinus Congestion
- ❑ Dry skin
- ❑ Stiff neck
- ❑ Smoke cigarettes (# of cigarettes a day: ___)
- ❑ Dry Mouth
- ❑ Sore throat
- ❑ Stiff shoulders
- ❑ Alternating fever and chills
- ❑ Sadness
- ❑ Difficulty breathing
- ❑ Melancholy

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Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

SPLEEN FUNCTION

- ❑ Low appetite
- ❑ Abrupt weight gain
- ❑ Abrupt weight loss
- ❑ Abdominal bloating
- ❑ Abdominal gas
- ❑ Gurgling noise in the stomach
- ❑ Fatigue after eating
- ❑ Easily bruised
- ❑ Hemorrhoids
- ❑ Pensive
- ❑ Worry
- ❑ Over-thinking
- ❑ Prolapsed organs (previously diagnosed, which organ? _____)

SPLEEN, STOMACH, LARGE INTESTINE, SMALL INTESTINE FUNCTION

- ❑ Loose
- ❑ Constipated
- ❑ Incomplete
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Mucous in stools
- ❑ Undigested food in stools

DAMPNESS TRAPPED IN THE BODY

- ❑ Mental heaviness
- ❑ Mental sluggishness
- ❑ Mental fogginess
- ❑ General sensation of heaviness in the body
- ❑ Swollen hands
- ❑ Swollen feet
- ❑ Swollen joints
- ❑ Chest congestion
- ❑ Nausea
- ❑ Snoring

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Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

STOMACH FUNCTION

- ❑ Large appetite
- ❑ Bad breath
- ❑ Mouth (canker) sores
- ❑ Burning sensation after eating
- ❑ Heartburn
- ❑ Acid regurgitation
- ❑ Ulcer (diagnosed)
- ❑ Bleeding, swollen or painful gums
- ❑ Belching
- ❑ Hiccups
- ❑ Stomach pain
- ❑ Vomiting

LIVER, GALL BLADDER FUNCTION

- ❑ Alternating diarrhea and constipation
- ❑ Headache at the top of the head
- ❑ Tight sensation in the chest
- ❑ Bitter taste in the mouth
- ❑ High-pitched ringing in the ears
- ❑ Gall stones (history or current)
- ❑ Limited Range-of-Motion, neck
- ❑ Limited Range-of-Motion, shoulder
- ❑ Frustration
- ❑ Depression
- ❑ Irritability
- ❑ Skin rashes
- ❑ Chest pain
- ❑ Anger easily
- ❑ Pain under the ribcage
- ❑ Tingling sensation
- ❑ Numbness
- ❑ Muscle spasms
- ❑ Muscle twitching
- ❑ Muscle cramping
- ❑ Seizures
- ❑ Tendon. ligament or joint problems
- ❑ Convulsions
- ❑ Lump in the throat
- ❑ Neck tension
- ❑ Drink alcohol
- ❑ Shoulder tension
- ❑ Vertigo

❑ Sexually transmitted disease (Which?_____)

❑ Recreational drugs (Which? _____ , How much per week? _____)

❑ Frequently unable to adapt to stress (What causes the stress?_____)

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Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

EYES (Liver function)

- ❑ Itchy
- ❑ Dry
- ❑ Blurry vision
- ❑ Far-sighted
- ❑ Bloodshot
- ❑ Watery
- ❑ Decreased night vision
- ❑ Hot
- ❑ Gritty
- ❑ Near-sighted

KIDNEY, URINARY BLADDER FUNCTION

- ❑ Frequent cavities
- ❑ Low back pain
- ❑ Bladder infections
- ❑ Easily broken bones
- ❑ Memory problems
- ❑ Wake during the night twice to urinate
- ❑ Sore knees
- ❑ Excessive hair loss
- ❑ Lack of bladder control
- ❑ Weak knees
- ❑ Low-pitched ringing the ears
- ❑ Fear
- ❑ Cold sensation in the knees
- ❑ Kidney stones
- ❑ Easily startled

URINATION

- ❑ Normal color
- ❑ Reddish
- ❑ Profuse
- ❑ Painful
- ❑ Urgent
- ❑ Dark yellow
- ❑ Cloudy
- ❑ Strong color
- ❑ Discharge
- ❑ Frequent
- ❑ Clear
- ❑ Scanty
- ❑ Burning
- ❑ Difficult

LIBIDO

- ❑ Normal
- ❑ High
- ❑ Low

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WOMEN ONLY

Regular menstrual cycle? ❑ Y ❑ N Number of children: _____ Age of first menstruation: _____

Average number of days of flow: _____ Vaginal discharge? ❑ Y ❑ N Pregnant? ❑ Y ❑ N

Number of pregnancies: _____ Age of menopause (if applicable): _____

Average number of days of entire cycle: _____ Bleeding between periods? ❑ Y ❑ N

Do you experience any of the following pre-menstrual syndromes?

❑ Nausea	❑ Vomiting	❑ Water retention	❑ Breast swelling
❑ Food cravings	❑ Headaches	❑ Migraines	❑ Breast tenderness
❑ Depression	❑ Irritability	❑ Anxiety	❑ Other emotions
❑ Dull pain, Where? _____		❑ Sharp pain, Where? _____	

Please fill out the following menstrual chart	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

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MEN ONLY

❑ Swollen testes ❑ Testicular pain ❑ Impotence ❑ Premature ejaculation

❑ Feeling of coldness or numbness in external genitalia ❑ Other_____

EVERYONE: MEDICATIONS, VITAMINS AND SUPPLEMENT LOG

Medical/Allergy alerts: _____

_____

Date Started	Medication/Vitamin/Supplement	Reason for taking	Dosage	Quantity	Frequency

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INFORMATION FOR YOUR ACUPUNCTURIST

DIETARY INTAKE

Please list typical foods eaten for each meal and amount of beverages consumed each day of the following:

Diet:	Beverages/Day:
Breakfast:	Water:
Lunch:	Pop:
Dinner:	Milk:
Snacks:	Juice:
	Coffee:
	Tea:
	Alcohol: