Client Name:

Oriental Medicine - Patient Intake Form

Thank you for coming. Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire. All your information will be confidential. If you have questions, please ask.

Contact Information

Today's Date: _____/_____/_____

Name:_____ Sex: F ☐ M ☐ DOB: _____/_____/_____ Age:____
Street:_____ Email Address:_____
City:_____ State:_____ Zip:_____ Phone Number:_____
Occupation:_____ Employer:_____
Emergency Contact:_____ Phone:_____
How did you find out about us? Walk By ☐ Friend/Relative ☐: _____ Website ☐ Internet Search Engine ☐ Doctor Referral ☐:_____ Other ☐: _____

Have you had acupuncture before? Y ☐ N ☐
Have you ever taken Chinese Herbal Medicine? Y ☐ N ☐

Major Health Complaint(s)

Please list in order of significance to you and **check which you would like us to focus on today**.
1. ☐_____ 4. ☐_____
2. ☐_____ 5. ☐_____
3. ☐_____ 6. ☐_____
When did the checked problem begin?_____
What kind of treatments have you tried?_____
What makes this problem worse?_____ Better?_____
Is there anybody in your family with the same problem?_____
Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

_____
_____

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P = Past C = Current**

P C	P C	P C	P C
☐☐Alcohol/Drug Abuse	☐☐Digestive Disorder	☐☐Hypertension	☐☐Nervous Disorder
☐☐Anemia	☐☐Epilepsy/Seizures	☐☐Jaundice	☐☐Pneumonia
☐☐Arthritis	☐☐Glaucoma	☐☐Kidney Disease	☐☐Stroke
☐☐Asthma	☐☐Heart Disease	☐☐Liver Disease	☐☐Thyroid Disorder
☐☐Auto Immune	☐☐Heavy Bleeding/Hemorrhage		☐☐Tuberculosis
☐☐Blood Transfusion	☐☐Hepatitis	☐☐Mental Illness	☐☐Vein Condition
☐☐Cancer	☐☐High Cholesterol	☐☐Migraines	☐☐Venereal Disease
☐☐Diabetes	☐☐HIV/Hepatitis	☐☐Other:_____	

Known allergies (food, medications, or other):_____
Significant trauma (car accident, sports injuries etc.):_____
Immunizations: ☐ In the past ☐ Never ☐
Hospitalizations/Surgeries (procedures and dates):_____
Do you have any sexually transmitted diseases? _____
Do you have a history of frequent antibiotic use? Please Describe._____
Allergy shots? Currently ☐ In the past ☐ Never ☐