Fieldlab Acupuncture

Patient Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Name _____ D.O.B _____

Address _____

Email _____ Phone # _____

Main problem you would like help with:

_____

_____

How long ago did this problem begin?

_____

Have you been given a diagnosis for this problem? _____
If so, what?

_____

What kinds of treatment have you tried?

_____

_____

Have they helped alleviate the condition/problem?

_____

Are you currently receiving any treatment for your problem? _____
If so, what?

_____

Past Illnesses	Dates
_____	_____
_____	_____
_____	_____

Past Surgeries	Dates
_____	_____
_____	_____
_____	_____

Significant Traumas (ex. car accidents, falls,…)	Dates
_____	_____
_____	_____
_____	_____

Medications: (include prescriptions, over the counter, vitamins, herbs, etc. taken within the past 3 months) _____ _____

_____ _____

_____ _____

_____ _____

Average Blood Pressure _____ / _____ Average Pulse Rate _____

Allergies:
_____
_____

Family Medical History (general health)
Mother's side
_____
Father's Side
_____
Siblings
_____
If any of the above are deceased, what was the cause?
_____

Current Emotional Health: _____ Current Quality of Life: _____
Occupation: _____ Stress Level: _____ Do you like your job? _____

Have you had any unusual stresses recently?
_____
Your favorite time of year: _____ Worst: _____
Hobbies and recreational habits:
_____
Do you exercise regularly? _____ please describe: _____
Do you smoke cigarettes? _____ if so, #/day: _____
Do you drink alcohol? _____ if so, #/week: _____

Please check how many times you use the following:

	Never	1 -3 times per month	1 time per week	2 - 4 times per week	Everyday
sugar					
caffeine					
fried foods					
raw foods					
spicy foods					
soda					
fast food					
white flour					

Cardiovascular

☐ Blood Clots ☐ Dizziness ☐ Cold Hands/Feet
☐ Shortness of Breath ☐ Fainting ☐ Irregular Heartbeat
☐ Varicose Veins ☐ Difficulty Breathing ☐ Chest Pain
☐ High Blood Pressure ☐ Swelling of Hands ☐ Palpitations
☐ Cold Sweats ☐ Low Blood Pressure ☐ Swelling of Feet

Gastrointestinal

☐ Bad Breath ☐ Vomiting ☐ Diarrhea ☐ Black Stools

☐ Belching ☐ Gastric Ulcers ☐ Constipation ☐ Hemorrhoids

☐ Acid Reflux ☐ Intestinal Gas ☐ Abdominal Pain ☐ Blood in Stools

☐ Nausea ☐ Bloating

Genito-Urinary

☐ Painful Urination ☐ Incontinence ☐ Discolored Urine ☐ STD's

☐ Frequent Urination ☐ UTI's ☐ Blood in Urine ☐ Erectile Dysfunction

☐ Urgent Urination ☐ Scanty Urination ☐ Kidney Stones

Males over 40 years old: Have you had your prostate examined? _____
If so, results:
_____

Gynecology & Pregnancy

☐ Irregular Periods ☐ Prolonged Flow ☐ Vaginal Discharge ☐ Cysts

☐ Painful Periods ☐ PMS ☐ Fibroids ☐ Clots

☐ Light Flow ☐ Heavy Flow ☐ Difficult Births ☐ Fertility Problems

_____ Age First Menses _____ Date Last Menses

_____ # Pregnancies _____ # Births _____ # C-sections

_____ # Miscarriages _____ # Abortions _____ # Premature Births

Neuro-Psychological

☐ Depression ☐ Headaches ☐ Dizziness ☐ Anxiety

☐ Migraines ☐ Seizures ☐ Tinnitus ☐ Irritability

☐ Head Injuries ☐ Loss of Balance ☐ Easily Angered ☐ Poor Memory

☐ Mood Swings ☐ Disorientation ☐ Areas of Numbness ☐ Visual Disturbances

☐ Weak Extremities ☐ Lack of Coordination

Musculoskeletal

☐ Neck Pain ☐ Wrist/Hand Pain ☐ Joint Pain ☐ Muscle Weakness

☐ Back Pain ☐ Hip Pain ☐ Weak Joints ☐ Muscle Spasms

☐ Scoliosis ☐ Knee Pain ☐ Arthritis ☐ Muscle Cramping

☐ Shoulder Pain ☐ Ankle/Foot Pain ☐ Recent Sprains ☐ Muscle Soreness

☐ Elbow Pain

Have you ever received psychiatric treatment?
_____
Have you ever considered or attempted suicide?
_____
Do you have any nervous habits?
_____
Do you have any other problems you would like us to be aware of?
_____
_____
_____

Please Circle areas of Pain or injury