Raleigh Acupuncture & Herbal Medicine

Intake Form

ID#:

Note: Personal information provided on this form and in the clinic is confidential. Please read the Notice of Privacy Practice

Name: _____ Sex: _____ Date: _____

Address: _____ Phone: h) _____

_____ c) _____

w) _____

E-Mail: _____ Occupation: _____

Date of birth: _____ Age: ____ Marital Status: ____ # of children: _____

In case of emergency, please contact: (Name)_____ Phone #:
(W)_____ (H)_____ Relationship:_____

Is there any privacy concerns when we contact you for schedules of appointments or events?

_____

What is your main condition that you will like to get help with? Please describe_____

_____

What kind of treatment have you had for this condition?_____

Have you had acupuncture treatment before? _____

Brief Medical History

Have you had any of the condition(s)? Please check all that apply:

AIDS/HIV____	Alcoholism____	Allergies (food, latex, etc.)___	Cancer____
Diabetes____	Drug Addiction____	Heart Disease____	Hepatitis____
Herpes____	Pacemaker____	Seasonal Allergies____	Seizures____
Tuberculoses____	Operations_____		Other_____

Are you currently taking any medications or are you currently under the care of another physician? _____

_____

Any significant family medical history?_____

_____

Please check any of the following concerning current emotional status: Normal____

Depressed____	Anxiety____	Panic attacks____
Sensitive____	Anger____	Overly excited____

Please check any of the following concerning your current Energy: Normal____
Low____ Up and down____ Exhausted____
Abundant____ Nervous energy____ Hyperactive____

Please check any of the following concerning Sleep: Normal___ Insomnia____
Nightmare___ Early wakeup___ Other_____

Please check any of the following concerning Temperature: Normal____
Feel cold easily____ Cold hands____ Cold feet____
Alternate hot and cold____ Feel hot easily____ Hot flashes____
Sensitive to weather changes____

Please check any of the following concerning Sweating: Normal
Sweat too easily____ Sweat too much____ Difficult____
Sweat too little____ Night sweats____

Please check any of the following concerning Skin conditions: Normal___
Dry___ Age-spots___ Flaccid___ Ulcer___ Rash___
Damp___ Red/Black spots___ Other_____

Please check any of the following concerning hyper/hypo sensitivities: None
To cold____ To hot____ To dampness____
To light____ To noise____ To airborne particles/odors____
To foods____ To drugs____ Other: _____

Please check any of the following concerning Appetite and Digestion: Normal____
Get hungry quickly____ Poor appetite____ Nausea____
Bloating____ Gas____ Heartburn___ Crave sweet/salt___ Indigestion___
Other_____

Please check any of the following concerning Bowel Habits: Normal____
Times per day____ Constipated____ Diarrhea____
Loose____ Incomplete____ with Blood____
Hard and dry____ Strong smell____ with Mucous____

Please check any of the following concerning Urination: Normal
Frequent____ Urgent____ Burning____ Cloudy____
Dark color____ Foul smell____ Difficult____ Dripping___
Incontinent___ Number of times per day _____
Number of times per night _____

For woman, please check any of the following concerning Menstrual Cycle:
Age of onset ____ Date of last period _____ How long did it last ____
Regular____ Irregular____ How many days per cycle ____
Color: Pale red____ Dark red____ Bright red____
Purplish____
Clots? Yes____ No____
Pain? Yes____ No____
Before flow____ During flow____ After flow____
Abdomen____ Back____ Breasts____
Emotional? Normal____ Irritable____ Sad____
Before___ During____ After____

Do you smoke? No Yes _____per day, for _____years

Do you use recreational drugs or alcohol on regular basis? Yes___ No___