Raleigh Acupuncture & Herbal Medicine

Intake Form

ID#:

Note: Personal information Practice	provided on this form and in t	the clinic is confidential. Please	e read the Notice of Privacy	
Name:		Sex:	Date:	
Address:	2	Phone: h)		
		c)_		
		w) _		
E-Mail:		Occupation:		
Date of birth:	Age:	Marital Status:	# of children:	
In case of emergency,	please contact: (Name)_	8 y	Phone #:	
W)(H)		Relationship:		
Is there any privacy co	oncerns when we contact	you for schedules of ap	pointments or events?	
· · · · · · · · · · · · · · · · · · ·				
What is your main co	ndition that you will like		e describe	
What kind of treatmen	nt have you had for this o			
Have you had acupur	cture treatment before?	* 0		
Brief Medical History	Z	e e		
Have you had any of	the condition(s)? Please o	heck all that apply:		
AIDS/HIV	Alcoholism	Allergies (food later	etc.) Cancer	
Diabetes	Drug Addiction	Heart Disease		
Herpes	Pacemaker			
Tuberculoses		beabona mergeo	Other	
	ing any medications or a		he care of another	
Any significant family	medical history?			
· · · · · · · · · · · · · · · · · · ·				
	e following concerning c			
	_ Anxiety		115 H	
Sensitive	Anger	Overly excited	d	

<u> </u>	e following concerning you		
Low	Up and down_ Nervous energy	Exha	usted
Abundant	_ Nervous energy	Нуре	eractive
	e following concerning Sle		
Manuare	_ Early wakeup	_ Other	
Please check any of th	e following concerning Ter	mperature: Nor	mal
Feel cold easi	ily Cold ha	ands	Cold feet
Alternate hot	ily Cold ha and cold Feel ho	t easily	Hot flashes
Sensitive to w	reather changes		
	3		
Please check any of th	e following concerning Sw	eating: Normal	
	sily Sweat t		Difficult
Sweat too litt	le Night s	weats	
Sweat too htt	ic ivigite 5	wears	
Please check any of th	e following concerning Ski	n conditions: Nor	mal
	Age-spots Flaccid_		
	Red/Black spots		
Danip	Ked/ black spots	Other	
Dlagas shoot if the	- 6-11	/1	. N
riease check any or in	e following concerning hyp	er/ ny po sensitivities	. None
10 cold	To not	10 dampnes	5
To light	To noise	To airborne	particles/odors
To foods	To hot To noise To drugs	Other:	
	e following concerning Ap		
Get hungry q	uickly Poor ap	petite Naus	ea
Bloating	Gas Heartbu	rn Crave sweet/	salt Indigestion_
Other			· ·
*			
DI 1 1 64			
Please check any of th	e following concerning Boy	vel Habits: Nor	mal
_	e following concerning Boy Constip		
Times per day	Constipa	ated	Diarrhea
Times per day Loose	Constipa	ated	Diarrhea
Times per day	Constipa	ated	Diarrhea
Times per day Loose Hard and dry	Constipe Incompl Strong s	ated ete mell	Diarrhea with Blood with Mucous
Times per day Loose Hard and dry Please check any of the	Constipation Incompleting Strong see following concerning Uri	ated ete mell nation: Nor	Diarrhea with Blood with Mucous mal
Times per day Loose Hard and dry Please check any of the Frequent	Constipation Incomplete Strong s e following concerning Uri Urgent	ated ete mell nation: Nor Burning	Diarrhea with Blood with Mucous mal Cloudy
Times per day Loose Hard and dry Please check any of th Frequent Dark color	Constiped Incomple Incomple Strong see following concerning Uringent Foul smell	ated ete mell nation: Nor Burning Difficult	Diarrhea with Blood with Mucous mal
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