Rivertown Acupuncture
60 Cedar Street
Dobbs Ferry, N.Y. 10502

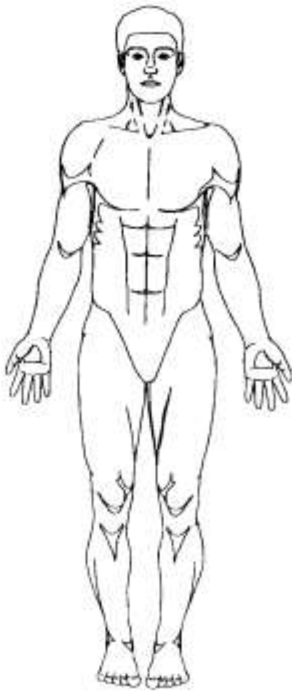
CONFIDENTIAL INTAKE FORM

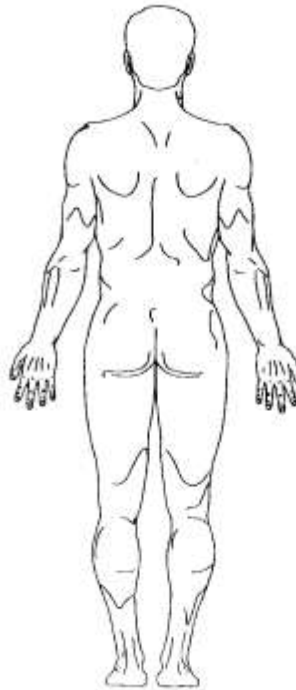
NAME: ____ AGE:_____GENDER:MALE □
FEMALE □
ADDRESS:____STATE:-
____ZIP:___________
OCCUPATION: ____DATE OF BIRTH
___/___/___
PHONE: MOBILE _________________________________OTHER:-
____
HOW DID YOU HEAR ABOUT US? ______________________________EMAIL
____
PHYSICIANS CARE? _______NAME & PHONE OF PHYSICIAN:
____
PLEASE DESCRIBE YOUR PRIMARY COMPLAINT:
____
____
____
HOW LONG HAVE YOU HAD THIS CONDITION? _________________WAS ONSET SUDDEN □
GRADUAL □
SYMPTOMS ARE WORSENED BY: (COLD OR HEAT, PRESSURE OR NO PRESSURE, EXERTION OR NONE) ?
____
____
SYMPTOMS BETTER BY
____
WHAT MEDICAL DIAGNOSIS HAVE YOU RECEIVED?
____
WHAT OTHER TREATMENTS HAVE YOU RECEIVED FOR THE CONDITION(S)?
____
____
____

ARE YOU TAKING ANY MEDICATION? PLEASE NOTE ALL MEDICATION, HERBS, VITAMINS AND MINERALS YOU TAKE, EVEN IF YOU TAKE THEM ONLY OCCASIONALLY.____________________________
____
____
____

PLEASE DESCRIBE ANY SECONDARY COMPLAINT:
____
____
____

ON THE DIAGRAM, PLEASE SHADE IN THE AREAS WHERE YOU FEEL SYMPTOMS ASSOCIATED WITH YOUR COMPLAINTS. PLEASE NUMBER THE COMPLAINTS (PRIMARY COMPLAINT #1; SECONDARY COMPLAINT #2:





Medical History:
Birth: Anything significant about your birth?___________________
____
Vaccination history: Any unusual reaction?-
____
Childhood illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.
______age:____
____
______age:____
____
______age:____
____

Adolescent illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.
____age:____
____
____age:____
____
____age:____
____

Adulthood: Any surgery or accidents? Please list in chronological order and indicate length or illness
or injury.
____age:
____
____age:
____
____age:
____

Family history: please note any outstanding illnesses in your immediate family (mother, father, siblings, maternal and paternal grandparents), such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders etc.
____
____
____
____

Underline current conditions. Put a **check mark** in the box for **former conditions.** Add any additional information regarding duration, frequency, intensity and pain regarding current symptoms.
Have you had any of these?
□ AIDS/HIV □ Cancer □ Lyme Disease □ Hepatitis A/B/C □ Seizures□ Alcoholism
□ Diabetes □ Multiple Sclerosis □ Tuberculosis□ Allergies □ Emphysema
□ Pacemaker □ Polio □ Asthma □ Heart Disease □ Lymph nodes removed
□ Rheumatic Fever □ Scarlet Fever □ Headache □ Birth Trauma □ Meningitis
□ Herpes □ Hypothyroid □ Hyperthyroid □ Osteoarthritis □ Rheumatoid Arthritis
____
____

Diet and Food:
How is your appetite? Good □ Poor □ No appetite □ Hungry all the time □
Any food cravings?:
____
List any food intolerances:
____
What is your relationship with food?
Are you always thirsty? Yes □ No □ Do you prefer Hot □ or Cold □ drinks?
How many glasses/cups do you have daily: Water ______ soda _____ Coffee/Tea ______
Alcohol ______day/wk_
Rate your taste preferences 1 to 5 (1=like most to 5=dislike):
Salty_____ Sour _____ Bitter _____ Sweet _____ Spicy _____
Exercise and Energy:
How is your
energy?____
What time of day is your energy: Highest? _____________ Lowest?_____________________
Do you fatigue easily?
____
Does movement make you feel : less tired □ or more tired □
What kind of exercise do you do?
____
How often do you exercise? ____________________Are you
consistent?_________________
Do you have unusual sweating? ______________ When?
____
Do you get dizzy with or after
exercise?____

Emotions and Sleep:
How do you feel

emotionally?____

Do you have (check all that apply): Panic attacks □ Depression □ Anxiety □ Bad Temper □Nervousness □ Fear attacks □ Poor memory □ Difficult concentration □ Moody in the morning □ Other: ______________________

Married or Stable relationship □ Single □

Do you carry stress?____

If you hold your stress in the body, where?____

How do you relax? ____

How do you feel about your work? ____

Do you use any prescription or non-prescription substances? _______________________

Anti-depressants □ Sleeping pills □ Painkillers □

How long do you normally sleep? _________ hours per night

I have difficulty with: Falling asleep □ Staying asleep □ Disturbed Sleep □

Waking up at about _________am/pm and not being able to fall asleep again because____

Muscles, Joints and Bones:

Do you have pain or tightness?_______________ Where? ______________________________
____

The pain is (check all that apply): Sharp □ Aching □ Numb □ Deep pain □ Burning □ Dull □ Superficial pain □ Tingling □ Pain worse or better with heat □ Pain worse or better with cold □ Pain worse in am or pm □ TMJ □ Pain worse or better with movement □

I have: Muscle cramping □ Muscle pain □ Repetitive strain □ Joint clicking □ Limitation of movement □ Stiffness □ Swelling □ Swollen joints □ Arthritis/joint pain □ Tendonitis □ Rheumatism □ Bone pain □ Weakness □

Other:______________________________________

Skin and Hair:

I have (check all that apply): Dry skin □ Skin rashes □ Itching □ Acne □ Eczema □ Hives □Hair loss □ Premature graying □ Psoriasis □

Other:____

Respiratory, Eyes, Ears, Nose, Throat & Head:

Do you smoke? Yes □ No □ _________ per day, for _____years

I have: Frequent colds □ Chronic runny nose □ Chronic cough □

Coughing blood □ Pain inhaling □ Shortness of breath on exertion/at rest □ Asthma□ Nose bleeds □Pain/red eyes □ Poor vision □ See spots □ Dizziness □ Cold sores □ Bleeding gums □ Dry mouth □Ear pain □ Ringing in ears (high pitch / low pitch) □ Clogged/popping ears □ Sinusitis □ Motion sick □ Frequent sore throat □

Cough up mucous □ How much?________________ Color of phlegm?__________________

Frequent headaches/migraines □

Describe:____

Cardiovascular:
Blood pressure: ____/____ Have you been diagnosed with heart trouble? Yes □ No □
I have (check all that apply): Chest pain □ Palpitations □ Irregular heart beat □ Phlebitis □
Varicose veins □ Cold hands and feet □ Poor circulation □
Diabetic Neuropathy □

Gastrointestinal:
I have: Belching □ Nausea □ Vomiting □ Vomiting of blood □ Ulcers □ Acid regurgitation □
Heartburn □ Hernia □ Indigestion □ Severe stomach pains □
Other : ________________________ Bowel movements: How often? ______ day/week
Painful bowel movement? Yes □ No □
I have: Irregular □ Constipation □ Diarrhea □ Gas □ Burning □ Hemorrhoids □
Undigested food in stool □ Loose stool □ Hard stool □ Blood in stool□ Itchiness □ Use laxatives □ Other:
____

Urinary & Genital:
Urination: How often? ____ times per day. Color: Pale yellow □ Dark yellow/orange □
I have or have had: Trouble starting stream □ Frequent urination □
Incontinence □ Trouble holding urine □ Pain □ Burning □ Dribbling when sneezing □
Urinary tract infections □ Blood in urine □ Kidney stones □ Other: ___________________
How is your sexual energy?
____
Do you have (check all that apply): Infertility □ Pain during sexual relations □
Other:
____

Women:
Are you currently pregnant? Yes □ No □
Are you presently trying to get pregnant? Yes □ No □
If you are trying to conceive, do you have the following information?
FSH _____________ LH _____________ IUI attempts _________ IVF attempts __________
At what age did you start menstruation?_______ Number of days between cycles: _____
Number of days of flow______ Color____________
I have or have had (check all that apply): Irregular menstruation □ Heavy flow □ Light flow □
No flow □ Clots □ Vaginal itching/burning □ Spotting between periods □
Discomfort/pain before period □ Discomfort/pain during period □ Other: ___________
Any vaginal discharge? Yes □ No □ Amount _________ Color ________ Frequency ______
Lumps in the breast □ Breast tenderness □ Other_________________________________
PMS symptoms: ______What makes these symptoms better? ________________________
Are you using birth control? What type?____
Number of pregnancies?____Number of deliveries?____Abortion(s)/Miscarriage(s)? ____
Pregnancy complications? Please describe:
____
Menopausal □ Symptoms:
____
Reduced sexual energy? Yes □ No □

Men:
I have: Prostatitis □ Impotence □ Penis blood/mucous discharge □

Pain associated with genitals □ Premature ejaculation □ Reduced sexual energies □
Seminal emission □ Testicular pain / Swelling □ Inguinal Hernia □
Other:
____