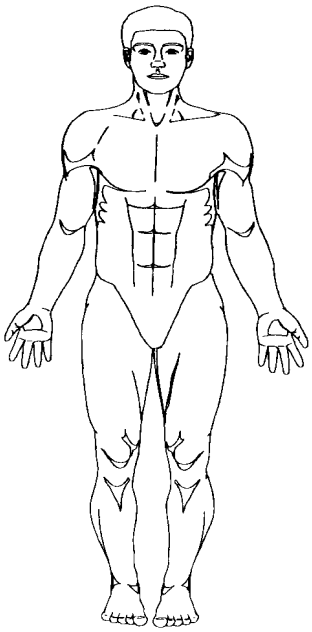
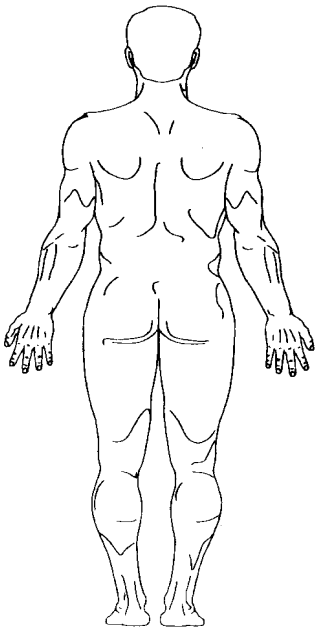
Rivertown Acupuncture
60 Cedar Street
Dobbs Ferry, N.Y. 10502

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 Stroke
 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: _____