

ABBOTT FAMILY CHIROPRACTIC, PC
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ACUPUNCTURE INTAKE FORM

Name: _____ File #: _____ Date: _____

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

- Hepatitis HIV High Blood Pressure Seizures Pacemaker Blood-Thinning Meds
 Pregnancy (certain or possible)

Please indicate the use and frequency of the following:

Coffee _____
Soda _____
Water _____
Alcohol _____
Recreational drugs _____
Tobacco _____

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health History:

What are the health problems for which you are seeking treatment?

How long have you had this condition?

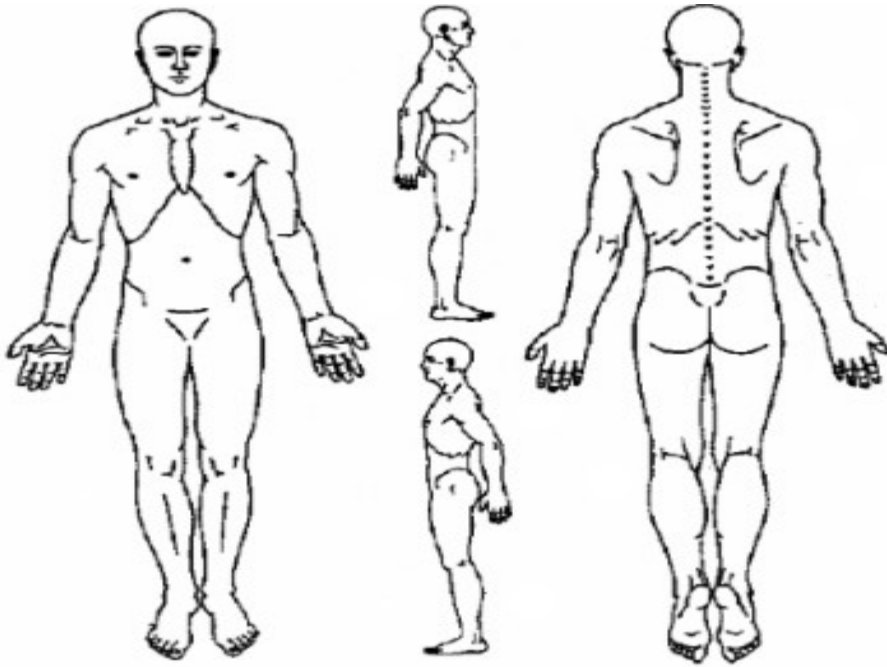
What other forms of treatment have you sought?

What helps your condition?

What aggravates your condition?

Please list any surgeries or major health incidents (accidents, etc.) in your life:

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain:

- Dull/achy sharp/stabbing burning tingling numbness electrical

What would you like to achieve with acupuncture treatment?

Are you interested in additional health services besides acupuncture? Yes No

Please check which services you might be interested in: Chiropractic Chinese Herbal Medicine

Therapeutic Massage Assisted Stretching/Yoga Relaxation techniques

Other _____

SYMPTOM SURVEY

Please “check” the symptoms or conditions your experience frequently:

Sp/St	Ht/P	Lu/Li	Ki/UB	Liv/GB
<input type="checkbox"/> excessive appetite	<input type="checkbox"/> insomnia	<input type="checkbox"/> cough	<input type="checkbox"/> low back pain	<input type="checkbox"/> eye problems
<input type="checkbox"/> loose stool/diarrhea	<input type="checkbox"/> palpitations	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> knee problems	<input type="checkbox"/> jaundice
<input type="checkbox"/> digestive problems/ indigestion	<input type="checkbox"/> cold hands & feet	<input type="checkbox"/> decreased sense of smell	<input type="checkbox"/> hearing impairment	<input type="checkbox"/> difficulty digesting oily foods
<input type="checkbox"/> vomiting	<input type="checkbox"/> nightmares	<input type="checkbox"/> nasal problems	<input type="checkbox"/> ear ringing	<input type="checkbox"/> gall stones
<input type="checkbox"/> belching, burping	<input type="checkbox"/> mentally restless	<input type="checkbox"/> skin problems	<input type="checkbox"/> kidney stones	<input type="checkbox"/> light-colored stool
<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> laughing for no reason	<input type="checkbox"/> claustrophobia	<input type="checkbox"/> decreased sex drive	<input type="checkbox"/> soft or brittle nails
<input type="checkbox"/> stomach bloating	<input type="checkbox"/> chest pains	<input type="checkbox"/> colitis/diverticulitis	<input type="checkbox"/> hair loss	<input type="checkbox"/> easily angered
<input type="checkbox"/> obsession in work	<input type="checkbox"/> poor memory	<input type="checkbox"/> constipation	<input type="checkbox"/> urinary problems	<input type="checkbox"/> difficult relationships
<input type="checkbox"/> blood in stool	<input type="checkbox"/> sadness	<input type="checkbox"/> allergies	<input type="checkbox"/> dental problems	<input type="checkbox"/> difficulty making decisions
<input type="checkbox"/> lack of appetite	<input type="checkbox"/> Depression	<input type="checkbox"/> asthma	<input type="checkbox"/> fatigue	<input type="checkbox"/> dizziness
<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> Anxiety	<input type="checkbox"/> get sick easily	<input type="checkbox"/> edema	<input type="checkbox"/> headaches
<input type="checkbox"/> easily bruised				
<input type="checkbox"/> I usually feel warm	<input type="checkbox"/> I usually feel chilled			

Please indicate if the following pertain to you:

NOTE: This Symbol ♀: before a question, indicates that it is for Women only.

Kidney Yin Xu:

- Do you have lower back weakness, soreness or pain?
- Do you have ringing in your ears?
- Is your hair prematurely gray?
- Do you have dark circles under your eyes?
- Do you have night sweats?
- Are you prone to hot flashes?
- Would you describe yourself as “afraid” frequently?
- Do you have dizziness?
- Do you have knee problems?
- ♀: Do you have vaginal dryness?
- ♀: Is your mid-cycle cervical mucus scanty or missing?

Kidney Yang Xu:

- Is your back sore or weak?
- Are your feet cold, especially at night?
- Are you typically colder than those around you?
- Is your libido low?
- Are you often fearful?
- Do you wake up at night or early in the morning because you have to urinate?
- Do you urinate frequently, and is the urine diluted and/or profuse?
- Do you have early morning loose, urgent stools?
- ♀: Do you have low back pain pre-menstrually?
- ♀: Do you have profuse vaginal discharge?
- ♀: Do you feel cold cramps during your period that respond to a heating pad?

Spleen Qi – Xue – Yang Xu:

- Are you often fatigued?
- Do you have poor appetite?
- Is your energy low after a meal?
- Do you feel bloated after eating?

- Do you crave sweets?
- Do you have loose stools, abdominal pain, or digestive problems?
- Are your hands and feet cold?
- Are you prone to feeling sluggish?
- Are you prone to heaviness or grogginess in the head?
- Do you have varicose veins?
- Are you prone to worry?
- Have you been diagnosed with low blood pressure?
- Do you sweat a lot without exerting yourself?
- Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
- Are you often sick, or do you have allergies?
- Have you ever been diagnosed with hypothyroid or anemia?
- Do you have hemorrhoids or polyps?
- ♀: Is your menstruation thin, watery, profuse, or pinkish in color?
- ♀: Are you more tired around ovulation or menstruation?
- ♀: Do you ever spot a few days or more before your period comes?
- ♀: Have you ever been diagnosed with uterine prolapse?
- ♀: Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

Blood Xu:

- Do you have dry, flaky skin?
- Are you prone to getting chapped lips?
- Are your fingernails or toenails brittle?
- Is your hair brittle or dry?
- Do you have diminished nighttime vision?
- Are your lips, the inner side of your lower eyelids, or tongue pale in color?
- ♀: Do you get dizzy or light-headed around your period?
- ♀: Are you losing hair on your head?
- ♀: Are your menses scant or late?

Blood Stasis:

- Do you experience periodic numbness of your hands and feet, especially at night?
- Do you have varicose or spider veins?
- Do you have red cherry spots (hemangiomas) on your skin?
- Do you have chronic hemorrhoids?
- Do you have dark spots in your eyes?
- Have you been diagnosed with any vascular abnormality or blood clotting disorder?
- ♀: Does your menstrual blood contain clots?
- ♀: Have you been diagnosed with endometriosis or uterine fibroids?
- ♀: Do you have piercing or stabbing menstrual cramps?
- ♀: your menstrual flow ever brown or black in color?
- ♀: Do you feel mid-cycle pain around your ovaries?
- ♀: Do you have painful, unmovable breast lumps?

Liver Qi Stagnation:

- Are you prone to emotional depression?
- Are you prone to anger and/or rage?
- Are your pupils usually dilated and large?
- Do you have difficulty falling asleep at night?
- Do you experience heartburn or wake up with a bitter taste in your mouth?
- ♀: Do you become irritable pre-menstrually?

- ♀: Do you feel bloated or irritable around ovulation?
- ♀: Does it feel as if your ovulation lasts longer than it should?
- ♀: Are your breasts sensitive/sore at ovulation?
- ♀: Do you experience nipple pain or discharge from your nipples?
- ♀: Do you have a lot of pre-menstrual breast distension or pain?
- ♀: Do you become bloated pre-menstrually?
- ♀: Are your menses painful?
- ♀: Do you feel your menstrual cramps in the external genital area?
- ♀: Is your menstrual blood thick and dark, or purplish in color?

Heart:

- Do you wake up early in the morning and have trouble getting back to sleep?
- Do you have heart palpitations, especially when anxious?
- Do you have nightmares?
- Do you seem low in spirit or lacking vitality?
- Are you prone to agitation or extreme restlessness?
- Do you fidget?
- Do you sweat excessively, especially on your chest?

Excess Heat:

- Are your mouth and throat usually dry?
- Are you often thirsty for cold drinks?
- Do you often feel warmer than those around you?
- Do you wake up sweating or have hot flashes?
- ♀: Do you breakout with red acne, especially pre-menstrually?
- ♀: Do you have a short menstrual cycle?
- ♀: Do you have vaginal irritation?

Dampness:

- Do you feel tired and sluggish after a meal?
- Do you have cystic or pustular acne?
- Do you have urgent, bright, or foul-smelling stools?
- Are you overweight?
- Do you have a wet, slimy tongue?
- Does your body feel like a barometer? Can you sense when it will rain?
- ♀: Does your menstrual blood contain stringy tissue or mucus?
- ♀: Are you prone to yeast infections and vaginal itching?
- ♀: Do you have fibrocystic breasts?

♀ **For Women:**

Age of first period _____ Date of last period _____ # of children (live births)

Number of days between periods (your cycle) _____ Number of days of flow _____

♀ **Check All that Apply:**

Color of flow: pale/light red red bright red dark red dark red/brown dark red/purple

of pads you use per day: 1st day ___ 2ND day ___ 3RD day ___ 4th day ___ 5th day ___

Pain and Cramping: No / Yes mild moderate severe
 1st day ___ 2ND day ___ 3RD day ___ 4th day ___ Before flow ___ After flow ___

Amount of flow:

- even throughout
- clots No / Yes 1st day ___ 2ND day ___ 3RD day ___ 4th day ___ Before flow ___ After flow
- spotting No / Yes 1st day ___ 2ND day ___ 3RD day ___ 4th day ___ Before flow ___ After flow
- light No / Yes 1st day ___ 2ND day ___ 3RD day ___ 4th day ___ Before flow ___ After flow
- heavy No / Yes 1st day ___ 2ND day ___ 3RD day ___ 4th day ___ Before flow ___ After flow

- Other symptoms related to menses:** Discharge PMS Headache Nausea
 Constipation Diarrhea Swollen Breasts Mood Swings Increased Appetite Decreased Appetite Insomnia

- Have you ever been diagnosed with:** fibroids fibrocystic breasts endometriosis ovarian cysts PID polycystic ovary syndrome STD _____

Fertility Information:

of IVF procedures _____

of IUI procedures _____

- Has a physician diagnosed a difficulty with fertility due to:** Female Factor Male Factor

Unexplained

Other _____