# Acupuncture & Oriental Medicine

## New Patient Intake— *General*

Today's Date: _____/_____/_____

**General Patient Information:** (*All information provided is held strictly confidential--see permission to share medical information section*)

Last Name: _____ First Name: _____
Home Phone: _____ Cell: _____ Email: _____
Work Phone: _____ Occupation: _____

Street Address: _____
City: _____ Zip Code: _____

Birth Date: _____/_____/_____ Age:_____ Height: _____ Weight: _____
Marital Status: ___Single ___Married ___Partnered ___Separated ___Divorced ___Widowed
Spouses Name: _____ Age: _____ Occupation: _____

In case of Emergency, who should we contact?: _____
Relationship: _____ Phone Number: _____

How did you hear about us? _____
Reason for your visit today: _____
How long have you had this condition?_____ Is it getting worse? Yes No
Does it affect your: Sleep _____ Work _____ Other _____
What seemed to be the initial cause? _____
What seems to make it better?_____
What seems to make it worse?_____
Are you under a physician's care now? NO YES For what? _____

**Please give us the name & phone number of your:**
Physician: _____
OB/GYN: _____
Reason you decided to try acupuncture & Oriental medicine? _____
How long did you think about it before you made your appointment? _____
Have you had acupuncture before? YES NO Chinese Herbal Medicines? YES NO
Surgeries: (include dates) _____ _____
_____ _____
Allergies: _____

**Please list all medications and supplements you are currently taking:**

| Medications/Supplements/Dosage | Reason/Objective | Date Started |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I hereby give my consent for treatment by Rachel R Russell, L.Ac.
I accept full financial responsbility for all medical services performed on my behalf.

_____ _____
Patient Signature Parent/Guardian Signature

**Family Medical History:** *(Please check any and all condition(s) members of your family have had)*

| **Illness:** | **Father** | **Mother** | **Sibling(s)** | **Grandparents** | **Aunt/Uncle** |
|---|---|---|---|---|---|
| Cancer | ____ | ____ | ____ | ____ | ____ |
| Diabetes | ____ | ____ | ____ | ____ | ____ |
| High Blood Pressure | ____ | ____ | ____ | ____ | ____ |
| Heart Disease | ____ | ____ | ____ | ____ | ____ |
| Allergies | ____ | ____ | ____ | ____ | ____ |
| Drug Abuse | ____ | ____ | ____ | ____ | ____ |
| Alcoholism | ____ | ____ | ____ | ____ | ____ |
| Mental Illness | ____ | ____ | ____ | ____ | ____ |
| Seizures | ____ | ____ | ____ | ____ | ____ |
| Strokes | ____ | ____ | ____ | ____ | ____ |
| Other: _____ | ____ | ____ | ____ | ____ | ____ |

**General Health Information:**

Major Health Complaints and/or Symptoms:

1. _____
2. _____
3. _____

Please explain how these conditions affect or impair your daily activities:

_____

_____

Describe your symptoms when they are at their worst:

_____

_____

What makes your symptoms better?

_____

_____

Are there any other complaints or conditions that you would like us to know about?

_____

_____

Please list any non-prescription drugs or recreational drugs you currently take:

_____

_____

**Medical Conditions/History:** *(Circle any conditions you have had, or are currently experiencing)*

| | | | | |
|---|---|---|---|---|
| Aids/HIV | Cancer | Hepatitis | Osteoporosis | Stroke |
| Alcoholism | Diabetes | Herpes | Pacemaker | Thyroid Disorder |
| Allergies | Emphysema | Lyme Disease | Pneumonia | Tuberculosis |
| Appendicitis | Epilepsy | High Blood Pressure | Polio | Typhoid Fever |
| Arteriosclerosis | Goiter | Measles | Rheumatic Fever | Ulcers |
| Arthritis | Gout | Menopause | Scarlet Fever | Venereal Disease |
| Asthma | Heart Disease | Multiple Sclerosis | Seizures | |

**Gynecological History:**

Age at your first period: _____
The first day of your last period? _____
Are your periods regular? YES NO
Number of days between periods: _____Number of days of bleeding: _____
Amount of bleeding? (*circle one*) LIGHT - - - - MEDIUM - - - - HEAVY
What color is the blood? PURPLE BROWN BLACK BRIGHT RED PINK
Is there clotting? YES NO
Do you bleed or spot between periods? YES NO
Have you ever taken medication to bring on your period? YES NO
Do your breasts become tender pre-menstrually? YES NO
Do you have pre-menstrual low back pain? YES NO
Do you have pain with menstruation? YES NO
Degree of pain: MILD - - - MODERATE - - - SEVERE
Pain relieved by over-the-counter medications? YES NO
Does the pain start with the onset of bleeding? YES NO
Begin before the onset of bleeding? YES NO
Persist more than 48 hours? YES NO

Have you ever used the Oral Contraceptive Pill YES NO
If yes, for how long? _____ When did you last use it? _____
How long did it take for your menses to regulate? _____

When was your last pap smear? _____ Result: _____
Have you ever had an abnormal pap? YES NO
If yes, what follow up was necessary_____
Have you ever had a mammogram? YES NO Result _____

Have you ever had a sexually transmitted disease?
Chlamydia, Gonorrhea, Herpes, Other: _____
When? _____ Was it treated? _____

**Please indicate number of:**

___ Pregnancies ___ Premature Births
___ Children ___ Ectopic Pregnancies
___ Miscarriages ___ Abortions

**Previous Gynecological Surgeries: Please Indicate Date(s) of Procedure**

C-Section Births _____
Dilation & Curettage (D&C) _____ Hysterosalpingogram (HSG) _____
Hysteroscopy _____ Laparoscopy _____
Other: _____

Do you have a stressful occupation? YES NO
Do you exercise regularly? YES NO
How often? _____
Do you use tobacco? Yes _____ No _____ # packs/day _____
Do you use alcohol? Yes _____ No _____ # drinks/wk _____

Have you experienced excessive loss of head hair? YES NO

**Overall Symptoms:** *(Please circle any of the following symptoms that currently pertain to*

**Body Temperature (Kidney & Organ System)**

| | | | |
|---|---|---|---|
| Cold hands | Hot body temperature | Profuse perspiration | Perspire easily |
| Cold feet | Cold body temperature | Lack of perspiration | Cold hips/buttocks |
| Sweaty palms | Afternoon Flushing | Night sweating | Incontinence |
| Sweaty feet | Hot Flashes | Strong thirst | Night time urination |

| | |
|---|---|
| Low back weakness or pain | Vaginal dryness |
| Fertile cervical mucus | Dizziness |
| Dark circles around your eyes | Ringing in your ears |
| Low back pain before your period | Low libido |
| Feet cold, especially at night | Early morning loose stools |
| Cold menstrual cramps | Premature gray hair |
| Colder than those around you | |

**Spleen Function**

Energy level: High Normal Low

| | | |
|---|---|---|
| Poor appetite | Feel heavy/sluggish | Energy lower after a meal |
| Heaviness in the head | Feel bloated after eating | Poor circulation |
| Crave sweets | Varicose veins | Bruise easily |
| Loose stools | Tired around ovulation | Spot before your period comes |
| Abdominal pain | Tired around menstruation | Nose cold |
| Indigestion | Nausea | Gas |
| Often sick | Hypoglycemia | |

**Stomach Function**

| | | | |
|---|---|---|---|
| Stomachache | Stomach ulcer | Acid reflux | Heartburn |
| Belching | Hiccups | Mouth ulcers | Bleeding Gums |
| Ravenous appetite | Bad breath | Nausea | Vomiting |

**Blood Function (liver, spleen, and heart system)**

| | |
|---|---|
| Menses scanty or late | Difficulty concentrating |
| Dry skin | Fainting |
| Chapped lips | Blurry vision |
| Weak or brittle nails | Poor night vision |
| Losing head hair | Hair dry/brittle |

**Heart Function**

| | | |
|---|---|---|
| Heart palpitations | Forgetfulness | Hot hands |
| Anxiety | Depression | Hot feet |
| Mental restlessness | High blood pressure | Rapid heart beat |
| Chest pain | Heart murmur | Restless dreams |
| Hemophilia | Tongue ulcers | Insomnia |
| Manic moods | Speech impediment | Arrhythmia |
| Severe shyness | Low blood pressure | Wake up in the early am |

**Lung Function**

| | | |
|---|---|---|
| Persistent cough | Chronic allergies | Dry or flaky skin |
| Nose bleeds | Nasal dryness | Sneezing |
| Difficulty breathing | Sinus congestion | Sore throats |
| Wheezing | Cigarette smoking | Allergies |

If you are a smoker, how many cigarettes per day? _____
How long have you been smoking? _____
If you are a smoker, do you want to quit? YES NO
Level of determination to quit: 1 2 3 4 5 6 7 8 9 10

**Bowl Function and Elimination**

| | | |
|---|---|---|
| Loose stools | Constipation | Difficulty moving bowels |
| I.B.S or colitis | Diarrhea | Blood in stools |
| Small, hard, dry stools | Crohn's disease | Incomplete stools |
| Mucus in stools | Less than 1 BM/Day | Eating disorder |

**Accumulated Dampness**

| | | |
|---|---|---|
| Mental fogginess | Swollen hands | Edema in the legs |
| Mental sluggishness | Swollen feet | Edema in the abdomen |
| Poor mental focus | Joint stiffness/ache | Chest congestion |

Heaviness of the head, the limbs or of the whole body

**Liver and Gallbladder Function**

| | | | |
|---|---|---|---|
| Chest pain | Irritability | Depression | Skin rashes |
| Chest tightness | Easy to anger | Pain in the ribcage | Acne |
| All over body tension | Easily frustrated | Headaches | Muscle spasms |
| Convulsions | Chronic neck tension | Migraines | Muscle cramps |
| Numbness/tingling | Shoulder tension | Gall stones | Lump in throat |
| Eye dryness | Seizures | Ringing in the ears | PMS |
| Breast tenderness | Nipple pain | Painful periods | |
| Wake with bitter taste in mouth | | Difficulty falling asleep at night | |
| Alternating diarrhea and constipation | | Easily overwhelmed by stressful circumstances | |

**Urinary Function**

| | | | |
|---|---|---|---|
| Normal color | Reddish color | Small amount | Dribbling |
| Dark yellow | Cloudy | Large amount | UTI |
| Clear color | Strong odor | Very frequent | Pain/burning urination |
| Frequency: _____ times at night | | Urgency | |
| _____ during the day | | | |

**Libido Function**

| | | |
|---|---|---|
| Normal | Diminished sex drive | Lack of desire |
| High sex drive | Sexual addiction | |