Kristen Carroll Gilbert, L.Ac.
Acupuncture Intake Form

Name: ____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: ____ Phone: ________________ Email:_______________________ Gender: M/F

Marital status: S M D W Or serious relationship: __________

Emergency contact: ____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? ____

2. For what reason? ____

3. Please identify the health concerns that have brought you here today in order of importance below:

Condition	**Past Treatment**
a. ____________________________	____
How does this condition affect you? ____________________________	
b. ____________________________	____
How does this condition affect you? ____________________________	
c. ____________________________	____
How does this condition affect you? ____________________________	
d. ____________________________	____
How does this condition affect you? ____________________________	

4. Please list any foods, drugs, medications or other substances you are hypersensitive to or allergic to (please include reaction):

____

____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

____

____

____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? ____

7. Do you have any infectious diseases? Y N If yes, please identify: ______________________________

9. **Height:** __________ **Weight:** Currently: __________ Past Maximum: _________ When? __________________

10. **Blood Pressure:** What is your most recent blood pressure reading? _______/_______ When was this reading taken? ________

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

General health as a child: _________________ Any significant childhood trauma _____________________________________

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When

14. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Other

15. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** (please circle any you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Eyes red/Itchy Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

17. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: ____

18. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

19. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers   Loose Stools   Nausea/Vomiting   Constipation   Passing Gas   Heartburn

Belching   Gall Bladder Disease   Liver Disease   Hepatitis B or C   Hemorrhoids   Abdominal Pain

20. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease   Painful Urination   Frequent UTI   Frequent Urination

Kidney Stones   Impaired Urination   Blood in Urine   Frequent Urination at Night

21. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles   Breast Lumps/Tenderness   Nipple Discharge   Heavy Flow

Vaginal Discharge   Premenstrual Problems   Clotting   Bleeding Between Cycles

Menopausal Symptoms   Difficulty Conceiving   Painful Periods

22. **Menstrual/Birthing History:**

1. Age of First Menses: _______   4. Birth Control Type: ________   7. # of Abortions: ________

2. # of Days of Menses: _______   5. # of Pregnancies: ________   8. Menopause? ________

3. Length of Cycle: _______   6. # of Miscarriages: ________   9. Hysterectomy? _________

23. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties   Prostrate Problems   Vasectomy   Testicular Pain/Swelling   Penile Discharge

24. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain   Muscle Spasms/Cramps   Arm Pain   Upper Back Pain   Mid Back Pain

Low Back Pain   Leg Pain   Joint Pain (if so, where?): ____

25. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness   Paralysis   Numbness/Tingling   Loss of Balance   Seizures/Epilepsy

26. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid   Hypoglycemia   Hyperthyroid   Diabetes Mellitus   Night Sweats   Feeling Hot or Cold

27. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia   Cancer   Rashes   Eczema/Hives   Cold Hands/Feet

Pacemaker, Hearing aid, Prosthesis, etc.? ____

Anything else we should know? ____

28. **Lifestyle:**

a. Three meals per day? Y N Describe diet briefly: ____

b. Exercise routine: ____

c. What do you do for relaxation?____

d. How many hours per night do you sleep? ________ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: ______________________ Employer: ______________ Hours/Week: _______

Do you enjoy work? Y/N Why/Why not? ________________________________

g. Nicotine/Alcohol/Caffeine Use: ____

h. Have you experienced any major traumas? Y N Explain: ____________________

____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Interests and hobbies: ____

How did you hear about this clinic? ______________________________