Acupuncture Intake Form

Welcome to our Clinic. At Inner Gate it is our goal to help each patient improve their quality of life and to achieve optimum health. Traditional Chinese medicine, which consists primarily of Acupuncture and Chinese Herbs, offers a unique approach to healing that nicely compliments other health care modalities. We work closely with physicians, alternative practitioners and you, our patient, in order to provide the best and most thorough treatment.

In order to serve you best we encourage you to fill out this survey in as much detail as possible. Successful health care is only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. All symptoms that you experience are relevant and important to us as Chinese Medicine practitioners. All information will be held in strict confidence. Thank you.

Name: ______________________________ Today's Date: ___/____/____

Preferred Pronouns: ________________ Date of Birth: ______/______/______ Age: __________

Gender (for insurance purposes): __________ Marital status (for insurance purposes): __________

Address: ______________________________City: ________________ State: ___ Zip: __________

Phone Number: (_____) ________-________ (home/mobile) Email Address: ______________________

How did you hear about us? Please specify. ____

Health Information

1. Please identify the health concerns that have brought you to our clinic in order of importance below:

Condition	Past Treatment
1) ____________________	____________________
How does this condition affect you?	____________________
2) ____________________	____________________
How does this condition affect you?	____________________
3) ____________________	____________________
How does this condition affect you?	____________________
4) ____________________	____________________
How does this condition affect you?	____________________

3. When and where did you last receive health care? ______________________________

   For what reason? ____

4. Height: ______ Weight: Currently: ______ Past Maximum: ______ When? ______

5. Blood Pressure: What is your most recent blood pressure reading? _____ /_____

   When was this reading taken? ____________________

6. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction): ____

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

____

____

8. Do you have any infectious diseases? Yes No If yes, please identify: ____________________

9. Childhood Illness (Please check any that you have had):

☐Scarlet Fever ☐ Diphtheria ☐Rheumatic Fever ☐ Mumps ☐ Measles ☐ German Measles ☐ Chicken Pox

10. Immunizations (Please check any that you have had):

☐ Covid-19 ☐ Polio ☐ Tetanus ☐ Measles/Mumps/Rubella ☐ Pertussis ☐ Diphtheria ☐ Hepatitis A & B ☐ Others: _______

11. Hospitalizations and Surgeries:

Reason	When	Reason	When

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

Reason	When	Reason	When

13. Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? ______________
b. Do you feel you have a healthy diet? Y N
c. Do you have any particular food cravings?______________________________________
d. Exercise routine: ____
e. Spiritual practice: ____
f. How many hours per night do you sleep? ______ Do you wake rested? Y N
g. Level of education completed: High School Bachelors Masters Doctorate Other
h. Occupation: _________________________ Employer: ______________________________
i. Hours/Week: ________ Do you enjoy work? Yes/No Why/Why not? ____________________
j. Nicotine/Alcohol/Caffeine Use: ____
k. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? ____________
l. Television habits: __________________________ Reading habits: ____________________________
m. Interests and hobbies: ____
n. Have you experienced any major traumas? Y N

Explain (if you feel comfortable) : ____

14. OBGYN:

a. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _________

b. Age of First Menses: ________ c. # of Days of Menses: _______ d. Length of Cycle: __________

e. Birth Control Type: ________ f. # of Pregnancies: __________ g. # of Miscarriages: ________

h. # of Abortions: ____________ i. # of Live Births: ___________

15. Body Systems Check:

Below, please **CHECK** any that you have now, and **UNDERLINE** any that you have experienced in the past:

Respiratory
- ☐ Pneumonia
- ☐ Frequent Common Cold
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Other Respiratory Problems

Head, Eye, Ear, Nose, & Throat
- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Glasses/Contacts
- ☐ Tearing/Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Frequent Sore Throat
- ☐ Teeth Grinding
- ☐ TMJ/Jaw Problems
- ☐ Hay Fever

Neurological
- ☐ Vertigo/Dizziness
- ☐ Paralysis
- ☐ Numbness/Tingling
- ☐ Loss of Balance
- ☐ Seizures/Epilepsy

Energy and Immunity
- ☐ Fatigue
- ☐ Slow Wound Healing
- ☐ Chronic Infections
- ☐ Chronic Fatigue Syndrome

Cardiovascular
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Swelling of Ankles
- ☐ High Blood Pressure
- ☐ Palpitations/Fluttering
- ☐ Stroke
- ☐ Heart Murmurs
- ☐ Rheumatic Fever
- ☐ Varicose Veins

Musculoskeletal
- ☐ Neck/Shoulder Pain
- ☐ Muscle Spasms/Cramp
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Joint Pain (if so, where?): ________________ ________________

Endocrine
- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Mellitus
- ☐ Night Sweats
- ☐ Feeling Hot or Cold

Gastrointestinal
- ☐ Ulcers
- ☐ Changes in Appetite
- ☐ Nausea/Vomiting
- ☐ Epigastric Pain
- ☐ Passing Gas
- ☐ Heartburn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Liver Disease
- ☐ Hepatitis B or C
- ☐ Hemorrhoids
- ☐ Abdominal Pain

Genito-Urinary Tract
- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Impaired Urination
- ☐ Blood in Urine
- ☐ Frequent Urination at Night

Emotional
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Mental Tension

Female Reproductive/Breasts
- ☐ Irregular Cycles
- ☐ Breast Lumps/ Tenderness
- ☐ Nipple Discharge
- ☐ Heavy Flow
- ☐ Vaginal Discharge
- ☐ Premenstrual Problem
- ☐ Clotting
- ☐ Bleeding Between Cycles
- ☐ Menopausal Symptoms
- ☐ Difficulty Conceiving
- ☐ Painful Periods

Male Reproductive
- ☐ Sexual Difficulties
- ☐ Prostrate Problems
- ☐ Testicular Pain/Swelling
- ☐ Penile Discharge

Others
- ☐ Anemia
- ☐ Cancer
- ☐ Rashes
- ☐ Eczema/Hives
- ☐ Cold Hands/Feet

Is there anything else we should know? ____

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