INTOUCH

PERSONAL & CONFIDENTIAL CLIENT INFORMATION

Name: _____ Date: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Occupation: _____ Person Responsible for Your Account: _____
Emergency Contact: Name _____ Phone Number: _____
Who shall I thank for referring you to my office?

Sex: (Please circle one) Male / Female Ht: _____ Wt: _____ Age: _____
Birthdate: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W
Number of Children: _____ Have you received acupuncture before? ☐ Y ☐ N

Please check and date any significant illnesses you or a blood relative have had:
(Place the letter "R" next to any illness contracted by your relative)

- ☐ AIDS
- ☐ Cancer
- ☐ Diabetes
- ☐ Emotional disorders
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Infectious diseases
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Sexually transmitted disease
- ☐ Tuberculosis

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	Duration	Prescriber

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Check any of the following statements that are true:

- ☐ I have known allergies
- ☐ I have a pacemaker
- ☐ I am taking Lithium
- ☐ I am taking Coumadin/Warfarin

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

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities, or food cravings that you have.

List any accidents, surgeries, or hospitalizations (including dates).

Lab Results (please include copies).

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FOR WOMEN

Age of 1st period (menarche) _____ # Days b/t periods _____
Age of last period (menopause) _____ # Days of flow _____
Days of flow _____ Color of flow _____ Clots (incl. color) _____

Nature of pain before, during, or after menses: (Please check):

- ☐ Cramping
- ☐ Burning
- ☐ Dull
- ☐ Consistent
- ☐ Stabbing
- ☐ Aching
- ☐ Bloating
- ☐ Intermittent
- ☐ Bearing Downwards

Please circle any of the following symptoms you experience relating to your menses:

- ☐ Discharge
- ☐ Vaginal dryness
- ☐ Headache
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Swollen breasts
- ☐ Mood swings
- ☐ Ravenous appetite
- ☐ Poor appetite
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Insomnia

Are you pregnant? ☐ Yes ☐ No
Pregnancies _____ # Live births _____ # Abortions _____ # Miscarriages _____
Date of last GYN exam _____ Pap Smear _____ Mammogram _____
Bone Density Scan _____ Results _____

Have you been diagnosed with any of the following? (Please check):

- ☐ Fibroids
- ☐ Endometriosis
- ☐ PID
- ☐ Fibrocystic breasts
- ☐ Ovarian cysts
- ☐ Other

Location of the pain (Please check):

- ☐ Lower abdomen
- ☐ Thighs
- ☐ Lower back
- ☐ Other

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FOR MEN

Date of last prostate check up _____ PSA results _____

Manual prostate exam results _____ Lab results _____

Frequency of Urination: ☐ Daytime ☐ Evening

Color of Urine: ☐ Clear ☐ Murky Odor: ☐ Y ☐ N

Please check symptoms experienced in relation to the prostate:

☐ Prostate problems	☐ Delayed stream	☐ Groin pain	☐ Incontinence
☐ Rectal dysfunction	☐ Decreased libido	☐ Dribbling	☐ Retention of urine
☐ Back pain	☐ Increased libido	☐ Testicular pain	☐ Premature ejaculation

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SYMPTOM SURVEY FOR BOTH MEN & WOMEN

Place a check mark next to every symptom that you commonly experience:

Spleen:

- ☐ Lack of appetite
- ☐ Excessive appetite
- ☐ Loose stool/diarrhea
- ☐ Digestive problems
- ☐ Belching
- ☐ Burping
- ☐ Heartburn/reflux
- ☐ Retention of food in stomach
- ☐ Tendency to become obsessive in work, relationships
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Recent use of antibiotics

Kidney:

- ☐ Knee problems
- ☐ Lower back pain
- ☐ Hearing impairment
- ☐ Ear ringing
- ☐ Kidney stones
- ☐ Decreased sex drive
- ☐ Hair loss
- ☐ Urinary problems
- ☐ Fatigue

Liver:

- ☐ Eye problems
- ☐ Jaundice
- ☐ Gall stones
- ☐ Light colored stool
- ☐ Soft or brittle nails
- ☐ Easily angered/agitated
- ☐ Difficulty making decisions
- ☐ Spasms/twitching muscles

Heart:

- ☐ Insomnia, difficulty sleeping
- ☐ Heart palpitations
- ☐ Cold hands and feet
- ☐ Nightmares
- ☐ Mentally restless
- ☐ Laughing for no apparent reason
- ☐ Abdominal pain
- ☐ Angina pains
- ☐ Chest pain
- ☐ Sciatic pain
- ☐ Headaches
- ☐ Pain or cold sensation in genitals

Lung:

- ☐ Blood in stool
- ☐ Cough
- ☐ Difficulty stopping bleeding
- ☐ Nasal problems
- ☐ Intolerance to weather change
- ☐ Skin problems
- ☐ Easily bruised
- ☐ Decreased sense of smell
- ☐ Tendency to catch cold
- ☐ Bronchitis
- ☐ Black tarry stool
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Feeling claustrophobic
- ☐ Allergies/hay fever