



## MAUREEN GOSS ACUPUNCTURE

### CONFIDENTIAL INTAKE FORM

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers \_\_\_\_\_

E-mail \_\_\_\_\_

Birth Date \_\_\_\_\_

Primary Care Practitioner's Name and Phone \_\_\_\_\_

What do you want treated with acupuncture? \_\_\_\_\_

What do you consider your main complaint? \_\_\_\_\_

How long have you had it? \_\_\_\_\_

What gives relief? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What medical diagnosis have you been given? \_\_\_\_\_

What medical treatment have you had? \_\_\_\_\_

What other treatment have you had? \_\_\_\_\_

Secondary complaint(s) \_\_\_\_\_

What would you like to achieve from treatment with acupuncture? \_\_\_\_\_

#### PAST MEDICAL HISTORY

Have you had any of these? Please circle all that apply.

Alcohol/Drug Dependency

Allergy

Anaphylaxis

Asthma

Autoimmune Disease

Bleeding Disorder

Cancer

Diabetes

Gastrointestinal Disorder

Heart Disease

High Blood Pressure

Hepatitis

HIV

Kidney Disease

Lung Disease

Neurological Disease

Seizure

Surgery

Thyroid Disorder

Trauma

Other Serious Illness \_\_\_\_\_

Current medications \_\_\_\_\_

## FAMILY MEDICAL HISTORY

Please list any of the above that apply.

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings(s) \_\_\_\_\_

## TEMPERATURE/SWEATING/THIRST Please circle all that apply.

Tendency to feel cold	Tendency to feel hot	Tendency to sweat	Tendency to feel thirsty
What season(s) do you prefer?	Spring      Summer	Fall      Winter	

## APPETITE/DIET Please circle all that apply.

No real appetite	Food cravings	Food allergies					
How many meals per day do you eat? _____	Did you eat yet today? _____						
Do you regularly ingest these? _____							
Meat	Sweets	Vitamins	Vegetables	Coffee	Supplements	Dairy	Alcohol
What taste(s) do you prefer?	Salty	Sweet	Spicy	Sour	Bitter		

## DIGESTION/ELIMINATION Please circle all that apply.

Reflux	Vomiting	Belching	Nausea	Bloating	Indigestion
Gas	Pain	Cramps	Burning	Blood in Stool	Hemorrhoids
Diarrhea	Constipation	Loose Stool	Incontinence	Urinary Frequency	Blood in Urine

## ENERGY/EXERCISE/SLEEP Please circle all that apply.

Generally energy is good	Tendency to tire easily or at certain time of day	Feel tired all the time
What type of exercise do you do? _____		
How often do you exercise? _____		
How many hours do you sleep per night? _____		
Use a sleeping pill	Difficulty falling asleep	Disturbed sleep

## EMOTIONS/MIND

What is your work and how do you feel about it? \_\_\_\_\_

What is your primary relationship and how do you feel about it? \_\_\_\_\_

When you are stressed, where do you feel it? \_\_\_\_\_

How do you relax? \_\_\_\_\_

How many vacation weeks do you take per year? \_\_\_\_\_

Please circle all that apply.

Anger	Irritability	Lack of Joy	Anxiety	Depression	Sadness
Fear	Difficulty Concentrating	Poor Memory	Use anti-anxiety medication	Use anti-depressant medication	

SKIN/HAIR Please circle all that apply.

Rash	Eczema	Psoriasis	Acne	Itching	Dryness	Hair Loss	Scars
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HEAD/EYES/EARS/NOSE/THROAT/BREATHING Please circle all that apply.

Headaches	Poor Vision	Poor Hearing	Ring in Ears	Nasal Congestion	Runny Nose
Sinusitis	Nose Bleeds	Sore Throat	Cough	Phlegm	Shortness of Breath
Asthma	Hay Fever/Allergies	Frequent Colds			

CIRCULATION Please circle all that apply.

Dizziness	Fainting	Irregular Heartbeat	Palpitations	Swelling
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MUSCLES/BONES/JOINTS Please circle all that apply.

Traumatic Injury	Osteoarthritis	Rheumatoid Arthritis	Tendonitis
Repetitive Strain Injury	Muscle Pain/Weakness	Joint Pain	

Where do you have pain or tightness? \_\_\_\_\_

Describe your pain by circling all that apply.

Sharp	Dull	Aching	Burning	Numb/Tingling
Better with Heat	Better with Cold	Better with Massage	Better with Exercise	

SEX/REPRODUCTION

Men – Please circle all that apply.

Erectile Dysfunction	Low Libido
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Women – Please circle all that apply.

Irregular Periods	No Periods	Spotting between Periods	Painful Periods	Heavy Periods
Vaginal Discharge	Pre-menstrual Symptoms	Menopausal Symptoms	Low Libido	

How many days in your menstrual cycle? \_\_\_\_\_ How many days does your period last? \_\_\_\_\_

Are you presently trying to get pregnant? \_\_\_\_\_ What form of birth control do you use, if any? \_\_\_\_\_

Have you ever been pregnant? \_\_\_\_\_ Number of full term pregnancies? \_\_\_\_\_