MAUREEN GOSS ACUPUNCTURE

COMPASSION·SKILL·INSIGHT

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.

Re ux	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   Dif culty 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	Dif culty 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

HEAD/EYES/EARS/NOSE/THROAT/BREATHING Please circle all that apply.

Headaches	Poor Vision	Poor Hearing	Ringing 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

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	

WOMEN – Please circle all that apply.

Irregular Periods	No Periods	Spotting between Periods	Painful Periods	Heavy Periods
Vaginal Discharge	Premenstrual 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? ______________________