DA De Cicco Acupuncture

Patient Intake Form

Information provided on this form is confidential. PLEASE PRINT.

Patient Information			
Name	Age	Sex Male Female	Today's date
Address		Occupation	
City, State		Zip	Date of birth
Telephone-Day		Telephone-evening	
Referred by			
Physician		Telephone	
What you want treated with acupuncture			
How long have you had this disease?		The onset of the disease was: Sudden / Gradual	
Symptoms relieved by		Symptoms worsened by	
What medical diagnosis have you received?			
What medications are you taking?			
For what conditions			
In general do you feel hot or cold?		Do you have chills or fever?	

Past medical History

Have you had any of these? (please CHECK ALL that apply)

❑ Hiv/Aids	❑ Cancer	❑ Lyme Disease	❑ Seizures
❑ Alcoholism	❑ Diabetes	❑ Multiple Sclerosis	❑ Tuberculosis
❑ Allergies	❑ Emphysema	❑ Pacemaker	❑ Latex allergy
❑ asthma	❑ Heart disease	❑ Polio	❑ Lymph nodes removed
❑ Birth trauma	❑ Hepatitis A/B/C	❑ Rheumatic Fever	❑ Other____

(your own birth) ❑ Herpes ❑ Scarlet fever
Are you currently Pregnant? Yes /NO | Are you presently trying to get pregnant? Yes/No
Describe any injuries, surgeries or major illnesses, whether hospitalized or not and the dates.

DIET & FOOD			
How is your appetite?			
Any food cravings?			
List any food intolerences:			
List any vitamins and supplements you are taking			
Describe meals for a typical day	**breakfast**	**Lunch**	**Dinner**
How often do you have:	Meat_____ day/week sugar/sweets____ day/week	coffee/tea(caffeinated)_____ Day/week Dairy(milk,cheese, yoghurt)____Day/week	
Are you always thirsty? Yes/No		Do you prefer hot drinks or cold drinks?	
Do you have unusual sweating? Yes/NO		When?	Other?
How many glasses do you consume daily? Water_____Soda_____Tea/coffee_____Alcohol Day/week			
Rate your preferences 1-5.(1=like mostly & 5=dislike) Salty_____Sour____Bitter_____Sweet____Spicy_____			

GASTROINTESTINAL	
I have (check what applies)	❑ belching ❑ nausea ❑ vomiting ❑ Vomiting blood ❑ Ulcers ❑ bloating ❑ acid ❑ Regurgitation ❑ Heart burn ❑ Hernia ❑ indigestion Severe stomach pain

	Other_____
Bowel movement: how often? _____Day/week	Painful bowel movement? Yes/NO
I have(check ALL that apply)	❑ irregular ❑ constipation ❑ diahrea ❑ gas ❑ burning ❑ itchiness ❑ hemorrhoids ❑ Undigested food in stool ❑ Blood in stool ❑ Hard stool ❑ Loose stool ❑ other_____

EXERCISE AND ENERGY		
How is your energy?		
What time of day is your energy:	Highest-	Lowest-
Do you get tired easily?		
What kind of exercise do you do?		
How often do you exercise?		

EMOTION AND SLEEP	
how do you feel emotionally?	
Do you have: (check all that apply)	❑ Panic attacks ❑ Depression ❑ anxity ❑ Bad temper ❑ nervousness ❑ Fear attack ❑ Poor memory ❑ Difficulty concentrating ❑ Other____
❑ Married/stable relationship ❑ single	How do you feel about your relationship?
How do you hold stress?	
How do you relax?	
How do you feel about your work?	
Do you use any prescription or non-prescription substances?	❑ antidepressants ❑ Sleeping pills ❑ others_____

How long do you often sleep? _____hours/night	I have difficulty with: (check all that apply)	

URINARY AND GENITAL	
Urination: How often? ____times a day	Colour: ❑ Pale yellow ❑ Dark yellow/orange
I have or have had (check ALL that apply):	❑ Trouble starting stream ❑ Frequent urination ❑ incontinence ❑ pain ❑ Trouble holding urine ❑ Dribbling when sneezing ❑ Urinary tract infection ❑ burning ❑ Blood in urine ❑ Kidney stone ❑ Other_____
How is your sexual energy?	
What kind of birth control do you use?	
Do you have (check all that apply):	❑ Infertility ❑ Pain during sexual relations ❑ Other

WOMEN				
At what age did you start mensturating?		Number of days between cycles?		
Number of days of flow?		Color?		
I have or have had(check all that apply):	❑ Irregular mensturation ❑ Heavy flow ❑ Light flow ❑ discomfort/pain before period ❑ Vaginal itching/burning ❑ Spotting between periods ❑ discomfort/pain after period ❑ clots ❑ other_____			
Any vaginal discharge?	Yes/No	Amount	Color	Frequency

PMS symptoms		
Number of pregnancies?	Number of deliveries?	Abortion(s)/Miscarriage(s)?
Menopausal symptoms?		

MEN	
I have(check all that apply):	❑ Prostatitis ❑ Impotence ❑ Penis blood/ mucous discharge ❑ Other

MUSCLES, JOINTS & BONES	
Do you have pain or tightness? Yes/No	Where?
The pain is (check all that apply):	❑ Sharp ❑ Aching ❑ Numb ❑ Deep pain ❑ Burning ❑ Dull ❑ Superficial pain ❑ Tingling ❑ Pain worse/better with heat ❑ Pain worse/better with cold ❑ Pain worse/better with pressure ❑ Pain worse/better in the am/pm
I have (check all that apply):	❑ Swollen joints ❑ Arthritis/ joint pain ❑ Tendonitis ❑ Rheumatism ❑ Bone pain ❑ Muscle cramping ❑ Muscle pain ❑ Repetitive strain injury ❑ Other

RESPIRATORY, EYES, EARS, NOSE THROAT & HEAD	
Do you smoke? yes/no	_____per day for _____ years
I have (check all that apply):	

	❑ Frequent colds ❑ Chronic runny nose ❑ Chronic cough ❑ Coughing blood ❑ Pain inhaling ❑ Shortness of breath ❑ asthma ❑ Nose bleed ❑ pain/red eyes ❑ Poor vision ❑ See spots ❑ dizziness ❑ Cold sores ❑ Bleeding gums ❑ Dry mouth ❑ Ear pain ❑ Ringing ears ❑ clogged/popping ears ❑ Frequent sore throat ❑ Cough up mucus: how much?_____color of phlegm?_____
	❑ Frequent headaches/migraines? Describe_____
	❑ Other_____

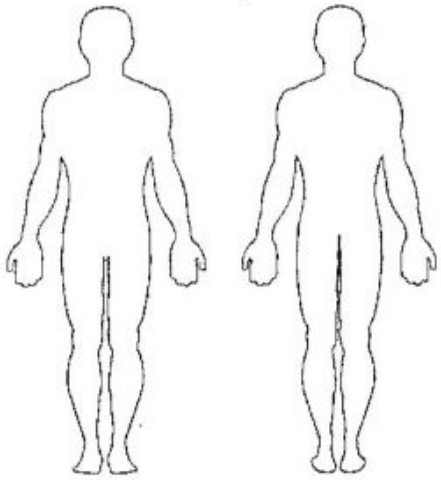
Cardiovascular	
Blood Pressure _____/_____	Have you ever been diagnosed with heart trouble? Yes/NO
I have(check ALL that apply):	❑ Chest pains ❑ palpitations ❑ Varicose veins ❑ phlebitis ❑ Cold hand and feet ❑ Poor circulation ❑ Irregular heartbeat ❑ other_____

Skin and Hair	
I have or often have(check all that apply)	❑ Dry skin ❑ Skin rashes ❑ itching ❑ Acne ❑ Eczema ❑ hives ❑ Hair loss ❑ Premature graying ❑ other_____

Family medical history (please list any significant family illness)
Mother
Father

Siblings
Grandparents

On the following drawing, shade the areas you feel should be addressed:



Thank you for filling out this questionnaire.

Assignment & Release: I certify that I, and/or my dependent(s), have insurance coverage with_____ (name of Insurance Company) and assign directly to **DeCicco Accupuncture** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. The above-named practitioner may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____

Relationship to Patient