Head To Heal Family Wellness Acupuncture Intake Form

Patient Name: _____

Address: _____ **Phone:** _____

email: _____ **Date of Birth:** _____/_____/_____

Major Complaints:
1)_____ **3)** _____

2) _____ **4)** _____

Details regarding Major Complaint:
Where is the problem located?_____
When did it start? _____
Have you had this pain before? When?_____
How did it start? _____
Is it getting worse? ____ coming and going___ getting better_____
How often does it bother you? _____
Is there a pattern- Time of day _____ Time of year/season_____
What makes it better? Heat___ Cold___ Pressure___ Other_____
_____
What makes it worse? Heat___ Cold ___ Pressure ___ Other _____
_____
Describe the pain: Dull/Aches ___ Shooting___ Other (pin prick, tight, squeezing, band sensation, expanding…) _____
Does the pain radiate anywhere?_____
Severity of pain out of 10 (10= worst pain) _____

Skin:
Do you have any skin conditions? Yes___ No ____
Do you have: Dry skin___ Itchy ___ Moist/clammy ___ Burning ___ changing moles or lumps ____ cysts ___boils ___ frequent skin rashes ___
Acne ___ hair loss/thinning ___ dry scalp ___ puffy skin ___ wrinkles___ easy to bruise ___ hives ____ scars (from what?) _____
Other_____

Head:
Do you get headaches? Yes___ No____ how often?_____
What area of the head? Temples___ behind eyes____ at top of head _____
Side(s)___ back ____ one sided____ worse side_____

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Do you have: memory loss?_____ loss of balance____ dizziness_____

Eyes:
How is your vision? _____ Any changes to your vision?_____
Do you have? Blurred vision____ Redness ____Night blindness ___ dry eyes ____ decreased vision ____ floaters: ____both eyes___Lots___few___

Ears:
How is your hearing? _____ any recent changes to your hearing _____
Have you experienced deafness in either or both ears? _____
Was the onset gradual ____ or sudden ____
Have you experienced ringing of the ears?_____ if so, check the following:
High pitched____ worse with pressure ____ low pitched ____ gradual onset___ better with pressure ____
Have you had ear aches? _____ear discharges ____ infections ____

Nose:
Nose bleeds frequently ___ sinus trouble ___ frequent colds___ other ____

Throat:
Sore throat (describe)_____ hoarse ___ difficulty swallowing ___ teeth or gum problems ___ swollen tongue____

Respiration and Voice:
Are you a loud talker___ soft talker___
Do you need to constantly clear your throat? _____
Do you get frequent coughs? If so, which kind: feeble(weak) ____ asthma__
Dry cough with phlegm production that is too sticky to cough up _____
Dry cough with small amounts of: phlegm ____ blood tinged _____
Cough with lots of phlegm___ persistent cough____ other_____
Consistency of phlegm _____ colour _____
Breathing: difficulty___ wheezing ___ mucus rattles when breathing ___ troubles breathing at night___ do you need 2+ pillows when sleeping?___ Shortness of breath? Yes ____no___ when?_____
If so, is it: worse on exertion? ____worse with a cough/asthma?_____
Associated with: heart palpitations ____ emotional problems____ loose stools ___ low back pain/arthritis _____
Chest: pain___ pressure ____ palpitations ____ heart disease ____
Other_____ Blood Pressure: high _____ low_____

Digestion:
how is your digestion?_____
How many bowel movements do you have daily?____
Stool consistency: hard___ soft___ loose____ diarrhea____ undigested food___ blood____ mucus____
Do your stools: sink____ float___
Colour: honey brown ___ grey___ black ___ green___ red ___ bloody ___ streaked with red___ multiple colours _____ other_____
Check if appropriate:
Loose stool: watery with mucus ____ undigested food and cold symptoms____ undigested food, bloating and gas___ early morning diarrhea (around 5am) _____ frequent with pain on defecation _____
Constipation: dry and malodorous ___ dry with fatigue ___ dry with cold symptoms ___
Alternating loose stools then hard____ dry then loose ____ pain on defecation and anal burning____ heavy, bearing down sensation in the anus ___ mucous stool ____ hemorrhoids ___ malodorous stool ___ bloating ___ red and swollen gums ___ indigestion/ heart burn ___
Belching ____ sour regurgitation _____

Urine:
Colour: light____ dark _____ other_____
Excess urination____ urination at night ___ infrequent or unable to urinate___ blood in urine ___ frequent bladder infections ___ water retention ___ where? _____ other _____
Does your water intake equal your output? _____ any incontinence?___

Thirst:
How much water do you drink/day? ___ litres
Excess thirst_____ No thirst____ Do you: chug ___or sip ____
Temperature preference of beverages _____

Appetite:
Excess appetite____ Poor appetite ____ Appetite keeps changing ____
Feel tired or weak if meal missed _____
What are your food cravings?
_____

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Female:
Age started menses _____ age stopped menses ____ vaginal discharge: yellow ____ clear ____ white ____ yellow ___ thick ____itching _____ odor resembling _____
Menstrual pain? ____ low back pain ___ irregular menses ____ no menses ____ clots with menses ____ size _____ colour: purple-red ____ black-red ____ bright red ____ brown flow at beginning of menses ___ number of pads or tampons used per day _____ heavy____ light bleeding _____
Water retention____ where? _____breast tenderness ___ moodiness _____
Low sex drive ____high ____hot flashes _____ when?_____ food cravings _____ Pregnant ____ Last monthly period _____ Last PAP test ___/___/___ Form of birth control _____
# of pregnancies ___ # of deliveries _____# of miscarriages _____ # of abortions _____ # of cesareans _____ any operations: cervix____ uterus ____ ovaries _____ any cysts____ fibroids ___ endometriosis _____

Male:
Low sex drive ___ lack of sex drive ___ impotence ___ ejaculation causing pain ___ penile discharge? _____ colour _____pain on urination _____
Burning____ premature ejaculation _____ prostate trouble___ other _____
Do you get a daily morning erection? Yes ____no ____ is it difficult to achieve an erection? Yes ____ no ____

Reproductive:
Libido- high___ average ___ low ___ Has it increased ___ decreased ____
Have you experienced fertility issues?____ if so, which partner and what has been tested? _____

Musculoskeletal:
Pain in: neck ___ shoulder ___ between shoulders ___ arms ___ hands ___ fingers___ hip ___ knee ___ big toe ___ upper back ___ mid back ___ low back ___ sore bones ___ loss of grip ___ swollen knees/elbows ____leg cramps at night ___ leg weakness ___ weak ankles ___ stiff all over ___ tingling? ___ where?____ muscle spasm ___ cramps ___ loss of feeling ___ where? ____ painful joints ___ bursitis ___ other_____

Neurological :
Nervous ___ depressed ___ easily angered ___ easily irritated ___ frequent crying ___worry/anxiety ___ mood swings ___ memory confusion __ poor concentration ___ suicidal ___ tremors ___ numbness /tingling ___ coordination problems ___ muscle weakness ___ other _____

Temperature and Circulation:

General temperature: Hot ____ cold ____ area:_____
Neutral ___ do you sleep with: feet out ___ light covers ___ no covers ____ normal ____ lots of covers ____ do you need to wear many layers to keep warm _____ do you like: warm drinks ___ spicy foods ___ are you cooler than others ___do you like cold, raw foods ___do you get a warm sensation around your chest, palms and soles of your feet all at the same time ____ do you bleed easily _____ do you have cold hands/feet _____

Sweating:

Rarely sweat ___ excess sweating ___ night sweat ___ If you have night sweats do you wake in a full sweat, not aware that you were sweating, then it stops when awake or moving ____ *or* do you sweat all night, you are aware of it, and it is due to the temperature of the room, and it does not change with moving ___ Do you sweat spontaneously (not on exertion or with movement) _____ do you find you are not sweating when others around you are?_____

Sleep:

Quality of sleep- poor ____good____excellent ____
Do you wake feeling refreshed? ____ # of hours of sleep/night _____are you a morning person ____ night person _____
Is it hard to stay awake after eating_____ do you nap____ Time _____ how often do you need to nap?_____
Do you have trouble falling asleep: ___ with dizziness and /or heart palpitations _____ with restlessness and dream disruption ____
Following a big/late meal____ or with irritability_____
Dreams: can't remember ___ don't have them____ excess dreaming ___ nightmares ___ day dreaming ____

Energy:

Please rank your average daily energy out of 10 (10 = good) _____

Mood:

Please describe your mood_____
The dominant emotion that you feel is: fear ____ anger ____ worry ____ jealousy ___ sadness ____ grief ____ depression ____ joy ___ other _____

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Stress:
None ____ moderate ___ severe ____ cause _____
How high is your stress out of 10 _____

Nutrition:
Do you: skip breakfast ____ eat a snack ___ hearty breakfast ____ # meals per day ___ biggest meal of the day is _____ do you eat if you are worried or rushed ____ # alcoholic drinks/week ____ # cigarettes/day ____ # of smoking years ____ eat the same food mostly ___ eat when not hungry ___ snack at night ___ hydrate without using water ___ always add salt to meals___ eat until full ____ eat many small meals throughout the day ____ forget to eat _____ I generally: make my own food _____ eat out _____

Thank you for taking the time to complete these forms.

_____ _____
Patient's Signature **Date**

Name _____ **(Please Print)**

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