TWIFORD ACUPUNCTURE

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Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential.

GENERAL INFORMATION

Name _____ Gender ❑ M ❑ F Date _____

Address _____ City _____ State _____ Zip _____

Email _____

Phone: ❑ Home _____ ❑ Work _____ ❑ Cell _____
(please indicate preferred contact number)

Occupation _____ Employer _____

Date of Birth _____ Age _____ Height _____ Weight _____

❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Separated/Divorced

Emergency contact _____ Relation _____

Emergency contact number: Home _____ Cell _____

Name of physician _____ Phone number _____
(No contact will be made without your permission)

Your signature _____

GOALS — What health concerns would you like to address through treatment

_____

_____

_____

_____

LIFESTYLE HABITS

Alcohol (drinks per week) _____ Coffee/Tea (cups per day) _____ Soda (regular or diet) _____

Cigarettes (packs per day) _____ Drug use (recreational) _____

Exercise ❑ Yes ❑ No How often? _____

What kind of exercise? _____

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FAMILY HISTORY — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
Good health						
Alcohol or other drug use						
Depression or mental illness						
Allergies						
High blood pressure/heart disease/stroke						
Cancer or tumors						
Diabetes						
Seizures						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Blood or bleeding disorders/anemia						
Thyroid disorders						
Kidney disorders						
Deceased (age)	N/A					

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

Year	Operation/Illness	Hospital or Treatment Location

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications	Dosage	For what condition?

Vitamins & Supplements	Dosage	For what condition?

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CONDITIONS/SYMPTOMS — Please mark any condition you have experienced in the past or currently.

General

past current

- ❑ ❑ Insomnia
- ❑ ❑ Dreams/ nightmares
- ❑ ❑ Fatigue
- ❑ ❑ Poor memory
- ❑ ❑ Strongly like cold drinks
- ❑ ❑ Strongly like hot drinks
- ❑ ❑ Recent weight loss/gain
- ❑ ❑ Cold hands & feet
- ❑ ❑ Chills
- ❑ ❑ Fever
- ❑ ❑ Bad breath
- ❑ ❑ Other (describe)

_____

Head & Neck

past current

- ❑ ❑ Headaches
- ❑ ❑ Migraines
- ❑ ❑ Stiff neck
- ❑ ❑ Dizziness
- ❑ ❑ Fainting
- ❑ ❑ Swollen glands
- ❑ ❑ Other (describe)

_____

Ears

past current

- ❑ ❑ Ringing
- ❑ ❑ Hearing loss
- ❑ ❑ Hearing aids
- ❑ ❑ Infections
- ❑ ❑ Earache
- ❑ ❑ Vertigo
- ❑ ❑ Other (describe)

_____

Eyes

past current

- ❑ ❑ Glasses/ contact lenses
- ❑ ❑ Blurred vision
- ❑ ❑ Poor night vision
- ❑ ❑ Spots or floaters
- ❑ ❑ Eye inflammation
- ❑ ❑ Double vision
- ❑ ❑ Glaucoma
- ❑ ❑ Cataracts
- ❑ ❑ "Lazy" eye
- ❑ ❑ Other (describe)

_____

How often checked?

_____

Nose, Throat & Mouth

past current

- ❑ ❑ Sinus infection
- ❑ ❑ Hay fever/ allergies
- ❑ ❑ Frequent sore throat
- ❑ ❑ Difficulty swallowing
- ❑ ❑ Mouth & tongue ulcers
- ❑ ❑ Frequent colds
- ❑ ❑ Nosebleed
- ❑ ❑ Dry nose
- ❑ ❑ Nasal congestion
- ❑ ❑ Loss of voice
- ❑ ❑ Thirst
- ❑ ❑ Excessive phlegm
- ❑ ❑ TMJ
- ❑ ❑ Facial pain
- ❑ ❑ Gum problems
- ❑ ❑ Dry mouth
- ❑ ❑ Dental problems?
  Last visit:_____
- ❑ ❑ Other (describe)

_____

Skin

past current

- ❑ ❑ Hives
- ❑ ❑ Rashes
- ❑ ❑ Eczema/psoriasis
- ❑ ❑ Night sweating
- ❑ ❑ Excess sweating
- ❑ ❑ Dry skin
- ❑ ❑ Easily bruised
- ❑ ❑ Changes in moles, lumps
- ❑ ❑ Itching
- ❑ ❑ Other (describe)

_____

Respiratory

past current

- ❑ ❑ Difficulty breathing
- ❑ ❑ Difficulty breathing (reclining)
- ❑ ❑ Wheezing
- ❑ ❑ Asthma
- ❑ ❑ Chronic cough
- ❑ ❑ Wet cough
- ❑ ❑ Dry cough
- ❑ ❑ Coughing up phlegm
- ❑ ❑ Coughing up blood
- ❑ ❑ Shortness of breath
- ❑ ❑ Tight chest
- ❑ ❑ Pneumonia
- ❑ ❑ Other (describe)

_____

Cardiovascular

past current

- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Chest pain or tightness
- ❑ ❑ Palpitation
- ❑ ❑ Rapid heart beat
- ❑ ❑ Irregular heart beat
- ❑ ❑ Poor circulation
- ❑ ❑ Swollen ankles
- ❑ ❑ Phlebitis
- ❑ ❑ Anemia
- ❑ ❑ History of heart disease
- ❑ ❑ Heart murmur
- ❑ ❑ Night sweats
- ❑ ❑ Tendency to be cold
- ❑ ❑ Tendency to be warm
- ❑ ❑ Other (describe)

_____

Gastrointestinal

past current

- ❑ ❑ Nausea
- ❑ ❑ Indigestion
- ❑ ❑ Stomach pain
- ❑ ❑ Diarrhea
- ❑ ❑ Constipation
- ❑ ❑ Poor appetite
- ❑ ❑ Excessive hunger
- ❑ ❑ Vomiting
- ❑ ❑ Gas
- ❑ ❑ Hiccups
- ❑ ❑ Acid regurgitation
- ❑ ❑ Bloating
- ❑ ❑ Laxative use
- ❑ ❑ Bloody stool
- ❑ ❑ Other (describe)

_____

Musculoskeletal

past current

- ❑ ❑ Joint pain/swelling
- ❑ ❑ Sore muscles
- ❑ ❑ Weak muscles
- ❑ ❑ Difficulty walking
- ❑ ❑ Limited range of motion
- ❑ ❑ Pain (describe)

_____

_____

_____

- ❑ ❑ Other (describe)

_____

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Neurological

past	current	
❑	❑	Seizures
❑	❑	Tremors
❑	❑	Numbness or tingling
❑	❑	Paralysis
❑	❑	Poor coordination
❑	❑	Pain (describe)
		_____
		_____
❑	❑	Other (describe)
		_____

Mental/Emotional

past	current	
❑	❑	Depression
❑	❑	Mood swings
❑	❑	Irritability
❑	❑	Difficulty relaxing
❑	❑	Loneliness
❑	❑	Sensitive
❑	❑	Shyness
❑	❑	Frequent crying
❑	❑	Worries frequently
❑	❑	Compulsive behaviors
❑	❑	Difficulty focusing
❑	❑	Hopeless outlook
❑	❑	Suicidal thoughts
❑	❑	Lose temper
❑	❑	Frustration
❑	❑	Other (describe)
		_____

Urinary

past	current	
❑	❑	Pain on urination
❑	❑	Frequent urination
❑	❑	Urgent urination
❑	❑	Blood in urine
❑	❑	Incontinence
❑	❑	Incomplete urination
❑	❑	Bedwetting
❑	❑	Wake to urinate
❑	❑	History of UTI
❑	❑	Kidney (specify)
		_____
❑	❑	Other (describe)
		_____

Male — Genital

past	current	
❑	❑	Impotence
❑	❑	Premature ejaculation
❑	❑	Nocturnal emission
❑	❑	Pain/itching of genitalia
❑	❑	Lumps in testicles
❑	❑	Increased libido
❑	❑	Decreased libido
❑	❑	Sexually transmitted disease (s) (specify)
		_____
❑	❑	Other (describe)
		_____

Women — Gynecology

past	current	
❑	❑	Menopause
❑	❑	Irregular periods
❑	❑	Menstrual cramps
❑	❑	Excessive blood flow
❑	❑	Menstrual blood clots
❑	❑	Abnormal pap smear
❑	❑	Vaginal infections
❑	❑	Vaginal pain/itching
❑	❑	Uterine fibroids
❑	❑	Endometriosis
❑	❑	Breast tenderness
❑	❑	Breast lumps, cysts
❑	❑	Increased libido
❑	❑	Decreased libido
❑	❑	Sexually transmitted disease (s) (specify)
		_____
❑	❑	Other (describe)
		_____

Currently pregnant:
trimester _____

Past pregnancies:
# of live births: _____
# of miscarriages _____
# of abortions _____

Other Information

_____

_____

_____

_____

_____

_____

Patient Signature _____ Date _____