A TOUCH of THERAPY

Adult Patient Intake Form

All medical information is confidential. We appreciate your time, thoughtfulness and honesty in completing this overview.

I. General Information.

Name: ____Date: _____________________________

Address: _____________________________________City/Zip: ____________________________

Phone: (home) __________________________________

(cell) __________________________________

(work) __________________________________

Can we leave a message? Y N

Email:____

Age: _________ Date of Birth: ________________ Height: _____________Weight: ______________

Occupation: ____________________ Hours per week: _______ Do you enjoy your work? ________

Gender: F M Married: ___ Separated: ___ Divorced: ___ Widowed: ___ Single: ___ Partnership: ___

Live with: Spouse: ___ Partner: ___ Parents: ___ Children: ___ Friends: ___

Alone: _________Other:_________

How did you hear about us?____

Have you ever had acupuncture before?____

Your medical doctor's name & phone number: ____

Emergency contact name & Relationship: ____

Emergency Contact Phone Number: ____

What is your primary reason for this visit?

1)

2)

3)

What initiates your symptoms? ____

What makes them better? ______________________What makes them worse? ________________

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? ____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive? ____

II. Health History Questionnaire.

Family History

Father: Living Age:__________ Health Status: ____________________________

Deceased Age at death:__________ Cause: _________________________________

Mother: Living Age:__________ Health Status: ____________________________

Deceased Age at death:__________ Cause: _________________________________

Brother(s): Health Status: ____

Sister(s): Health Status: ____

Children: Boy(s) # _______ Girl(s) # ________ Health Status: _______________________

Circle illnesses that have occurred in any of your blood relatives:

Alcoholism	Bleed easily	Diabetes	Heart Disease	Kidney Disease	Obesity
Allergy	Cancer	Epilepsy	Mental illness	High blood pressure	Stroke

Other:____

Personal History

Circle any illnesses or conditions you currently have or have had in the past:

AIDS/HIV	Bleed Easily	Heart Disease	Multiple Sclerosis	Shingles
Alcoholism	Cancer	Hepatitis	Vascular Disease	Stroke
Allergies	Chicken Pox	High Blood Pressure	Whooping Cough	Thyroid Disorder
Anemia	Diabetes	Jaundice	Pneumonia	Tuberculosis
Antibiotic Use	Epilepsy	Kidney Disease	Polio	Ulcers
Asthma	Glaucoma	Mental Disorder	Rheumatic Fever	Malaria

Other: ____

Do you have a PACEMAKER? Yes No

List any surgeries, serious illnesses, broken bones, hospitalizations, etc.: ______________________

____

____

Allergies: Are you allergic or hypersensitive to any:

Drugs? ____

Foods? ____

Alcohol? ____

Check the immunizations you have had:

__Chicken pox
__Influenza
__Diphtheria/Pertussis/Tetanus
__Measles/Mumps/Rubella
__Hepatitis B
__Tetanus only
Other: ____

List the Date and Results of last medical tests below:

DATE	TEST	RESULTS	DATE	TEST	RESULTS
	Cholesterol			Pap Smear	
	Hepatitis			Physical	
	HIV test			PSA (prostate)	
	Mammography			Stool	
	MRI			Other	

Current Medications (list ALL you are taking): ____
____
____
____
____
____
____
____

Currents Herbs/Vitamins/Supplements (list ALL you are taking): _______________________________
____
____
____
____
____
____
____

Is there anything else you would like to share with us?

Patient Signature: ____Date: ________________