Alexis Sarandon Acupuncture **Intake Form** Today's Date ____ /____ /____

Name, First and Last :			Age:	DOB:	Sex:
Address:	City:	State:	Zip Code:		
Main Phone # (best no. to contact you):	Secondary Phone #:	Email:			
Name of Emergency Contact:	Emergency Contact #:	Relationship to you:			
Occupation:	Your Primary Physician:	Physician's Phone #:			
Have you had acupuncture before?	If yes, for what and when	Who referred you to us:			

Reason for seeking treatment today

Primary Complaint:_____

How long have you had this condition?_____ The onset was Sudden ___ gradual___

Symptoms relieved by_____ worsened by_____

Medical diagnosis you have received: _____ From whom: _____

Treatments you have received for this condition _____

Secondary Complaint:_____

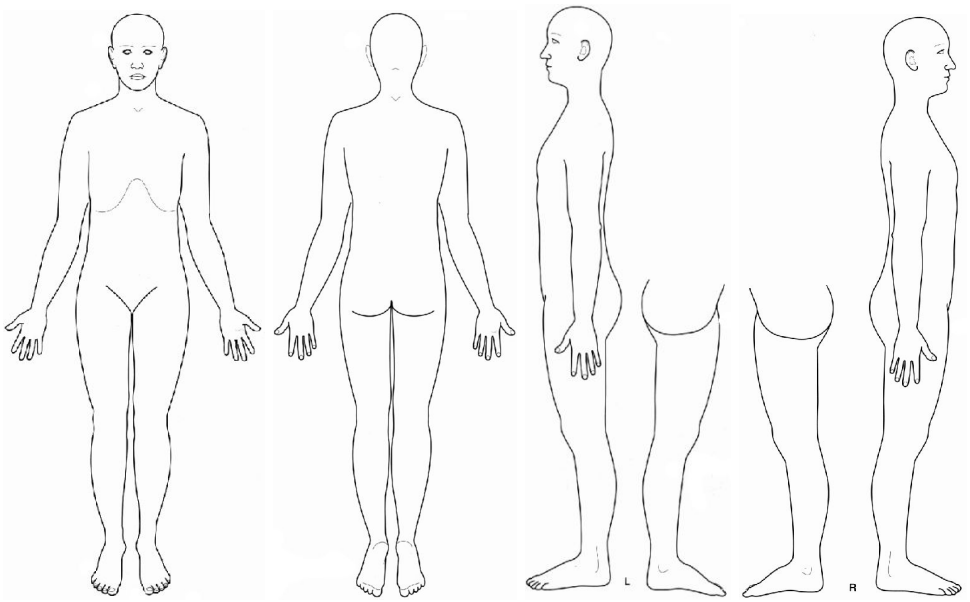
How long have you had this condition?_____ The onset was Sudden ___ gradual___

Symptoms relieved by_____ worsened by_____

Medical diagnosis you have received: _____ From whom: _____

Treatments you have received for this condition _____

On the following drawings, shade in the areas where you feel discomfort.



MEDICAL HISTORY

MEDICATION	**LIFESTYLE INFORMATION**	**Past Medical History**
List the medications you are currently taking: _____ _____ _____ _____ _____ _____ _____ _____	Do you.... Smoke Tobacco YES NO Drink Alcohol YES NO Use Recreational Drugs YES NO Are concerned about.. Stress YES NO Energy Level YES NO Sexual Drive YES NO Eating Habits YES NO If yes to any above, please describe:	Please list any chronic and serious illnesses. Include any surgeries and/or hospitalizations. **AGE** **CONDITION/SURGERY** ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____

Family Medical History: (Please list any significant family illnesses)

Mother:_____

Father:_____

Siblings:_____

Grandparents:_____

Have you had any of the following condition(s)? Circle C or P. C: current P: Past, now resolved

C P AIDS/HIV	C P Fibromyalgia	C P Pacemaker
C P Alcoholism	C P Heart Disease	C P Polio

C P Allergies (food, latex)	C P Hepatitis A/B/C	C P Rheumatic Fever
C P Asthma	C P Herpes	C P Scarlet Fever
C P Birth Trauma	C P Joint Replacements	C P Seasonal Allergies
C P Cancer	C P Lyme's Disease	C P Seizures
C P Diabetes	C P Lymph Nodes removed	C P Sinus Infections
C P Drug Addictions	C P Multiple Sclerosis	C P Tuberculosis
C P Emphysema		

Please use this space to provide any other information about your health that you would like us to know.

_____

_____

_____

_____

_____

_____

_____

SYMPTOM BY SYSTEM

Please indicate all symptoms below that you currently experience.

MUSCULOSKELETAL	RESPIRATORY	EYES, EARS, NOSE & THROAT	
• Joint clicking • Limited movement • Stiffness • Spasms • Swelling • Weakness • Pain • OTHER (Explain)	• Chest pain/tightness • Cough • Coughing up blood • Shortness of breath • Sore throat • Mucus • Wheezing • OTHER (Explain)	• Loss of vision • Eye pain • Tearing or eye dryness • Eye discharge • Eye redness • Ear discharge • Ear itching • Ear pain &/or infections • Loss of hearing	• Ringing or buzzing in ears • Problems with balance • Sense of smell impaired • Nasal stuffiness • Nose bleeds • Sinus pain, infections • OTHER (Explain)

NEUROLOGICAL	DIGESTIVE	UROGENITAL	CARDIOVASCULAR/ENERGY
• Confusion • Difficulty concentrating • Dizziness	• Bloating • Abdominal pain • Heartburn	• Incontinence • Difficulty w/flow • Dribbling	• Chest pain/pressure • High Blood pressure • Low blood pressure • Diabetic neuropathy

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- Gait disturbance
- Headache
- Numbness and/or tingling
- Coordination Problems
- Severe forgetfulness
- Tremor
- Visual disturbance
- Weakness
- OTHER (Explain)

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- Constipation
- Diarrhea
- Gas
- Indigestion
- Nausea
- Vomiting
- Constant Hunger
- No appetite
- OTHER (Explain)

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- Kidney Stone
- Urgent urination
- Frequent urination
- Pain on urination
- Burning Sensation
- Cloudy Urine
- Blood in Urine
- OTHER (Explain)

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- Cold hands and feet
- Cold sweats
- Poor circulation.
- Blood clots.
- Bruise easily.
- Palpitations
- Fatigue
- OTHER (Explain)

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PSYCHOLOGICAL

- Grief
- Sadness
- Anxiety
- Anger
- Feeling manic
- Worried
- Panic
- Mood swings
- OTHER (Explain)

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SKIN

- Dry skin
- Eczema
- Psoriasis
- Itching
- Acne
- Dry hair
- Hair loss
- Brittle nails
- Unusual sweat
- OTHER (Explain)

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FOR WOMEN ONLY

Age at first menses: _____
Last menses start date:___/____
Length of full cycle: _____days
Length of menses: _____days

Are you pregnant? YES NO
Trying to become pregnant? YES NO
Have you ever been pregnant? YES NO
If yes, how many pregnancies:
Births: # Miscarriages: # Abortions:

- Abnormal vaginal bleeding
- Fertility concerns
- Irregular menstruation
- No menses
- Pain with menses
- Painful sex
- Unusual discharge
- Pelvic pain
- Premenstrual symptoms
- Sexual dysfunction

- Menopausal Symptoms

Age at last menses:_____
Age changes began:_____

- Hot flashes
- Night sweats
- Vaginal dryness
- Loss of sex drive

- OTHER (Explain)

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SLEEP

- Difficulty falling asleep
- Dream disturbed sleep
- Wake up during night
- Not rested on waking
- OTHER (Explain)

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FOR MEN ONLY

- Fertility concerns
- Prostate problems
- Sexual dysfunction
- Unusual discharge
- OTHER (Explain)

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