Acupuncture Center of Kalamazoo

Patient Intake Form

Today's Date _____

Name | Date of Birth

Emergency Contact Name & Phone Number | Relationship

Patient Information

Home Phone ☐ mark if preferred contact | Work Phone ☐ mark if preferred contact | Cell Phone ☐ mark if preferred contact

Address

City | State | ZIP Code

E-mail address

Height | Weight | Age

Main Problem

Primary Physician | Referred by

Other Concurrent Therapies/Treatment

5708 Venture Court, Suite A
Kalamazoo, MI 49009

269.888.2471

info@acupuncturekalamazoo.com

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MEDICAL HISTORY

We hope you will answer the questions on this medical history form as thoughtfully as possible. Many of the questions that follow may not seem directly related to your main complaint or reason for seeking care. However, the answers to these questions, as well as the information you provide in the office, will determine the individualized approach we take to begin your treatment. ALL THE INFORMATION IN THIS QUESTIONNAIRE IS CONFIDENTIAL BY LAW.

Significant Illnesses:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Hepatitis ☐ Rheumatic Fever

☐ Thyroid Disease ☐ Seizures ☐ Schizophrenia or Bipolar Disorder ☐ Other: _____

Other significant details:

Surgeries *(include date if possible)*:
Allergies: *(drugs, chemicals, foods, etc.)*
Medications: *(Taken within the last 2 months incl. vitamins, over-the-counter drugs, herbs, etc.)*

Habits:

Do you have a supportive relationship? ☐ Yes ☐ No How many hours do you sleep at night? _____

Do you exercise? ☐ Yes ☐ No If yes, what kind/how often? _____

Any significant trauma (auto accident, falls, serious injury?) ☐ Yes ☐ No _____

Do you drink alcoholic beverages? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If no, but smoked previously, how many years? _____

Family Medical History:

☐ Alcoholism ☐ Allergies ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure

☐ Seizures ☐ Stroke ☐ Other: _____

REVIEW OF CURRENT SYMPTOMS

SKIN, HAIR and NAILS

☐ Rashes	☐ Itching	☐ Ulcerations	☐ Hives
☐ Eczema	☐ Pimples	☐ Dandruff	☐ Loss of Hair
☐ Change in hair/skin texture	☐ Psoriasis	☐ Toenail or Fingernail Issues	☐ Other _____

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HEAD, EYES, EARS, NOSE and THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ General Headaches
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Poor Vision
- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Spots in Eyes
- ☐ Cataracts
- ☐ Blurry Vision
- ☐ Sinus Problems
- ☐ Ear Aches
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Nose Bleeds
- ☐ Mucus
- ☐ Dry Throat
- ☐ Dry Mouth
- ☐ Copious Saliva
- ☐ Teeth Problems
- ☐ Jaw Clicks
- ☐ Facial Pain
- ☐ Grinding Teeth
- ☐ Sores on Lips or Tongue
- ☐ Recurrent Sore Throat
- ☐ Gum Problems

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Chest Pain
- ☐ Cold Hands/Feet
- ☐ Swelling in Hands/Feet
- ☐ Dizziness
- ☐ Fainting
- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Difficulty Breathing
- ☐ Other:_____

RESPIRATORY

- ☐ Cough
- ☐ Coughing Blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tight Chest
- ☐ Difficulty Breathing Lying Down
- ☐ Production of Phlegm: *what color?* _____
- ☐ Other Lung Problems: _____

GASTROINTESTINAL

Bowel Movement
frequency? _____
color? _____
odor? _____
texture/form? _____

- ☐ Vomiting
- ☐ Nausea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Gas/Bloating
- ☐ Belching
- ☐ Diarrhea
- ☐ Black Stools
- ☐ Sensitive Abdomen
- Laxative use: _____/week
- ☐ Bad Breath
- ☐ Rectal Pain
- ☐ Bloody Stools
- ☐ Pain or Cramps
- type: _____

GENITO-URINARY

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Urgency to Urinate
- ☐ Unable to Hold Urine
- ☐ Venereal Disease
- ☐ Impotence
- ☐ Wake Up to Urinate
- *How often?* _____/*night*
- *Time?* _____
- ☐ Issues w/Sex Drive or Libido

GYNECOLOGY

Age at First Menses _____ Days of Flow _____ Days of Cycle (day 1 to final day) _____

Flow ☐ Heavy ☐ Medium ☐ Light Spotting ☐ Before ☐ After

- ☐ PMS Symptoms
- ☐ Clotting
- ☐ Endometriosis
- ☐ Polyps
- ☐ Cyst
- ☐ Fibroids
- ☐ Excess Vaginal Discharge
- ☐ Vaginal Dryness

Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Ovulation Symptoms _____ ☐ Hot Flashes ☐ Night Sweats

Menopause age ____ ☐ Natural ☐ Induced Perimenopause Symptoms_____ ☐ STDs_____

MUSCULORSKELETAL

- ☐ Neck Pain
- ☐ Muscle Pain
- ☐ Back Pain:
- *Where?* _____
- ☐ Joint Pain
- ☐ Other Joint or Bone Problems: _____

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of Numbness
- ☐ Poor Memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Easily Stressed
- ☐ Bad Temper
- ☐ Treated for Emotional Problems
- ☐ Considered/Attempted Suicide
- ☐ Vivid Dreams/Nightmares
- ☐ Other? _____

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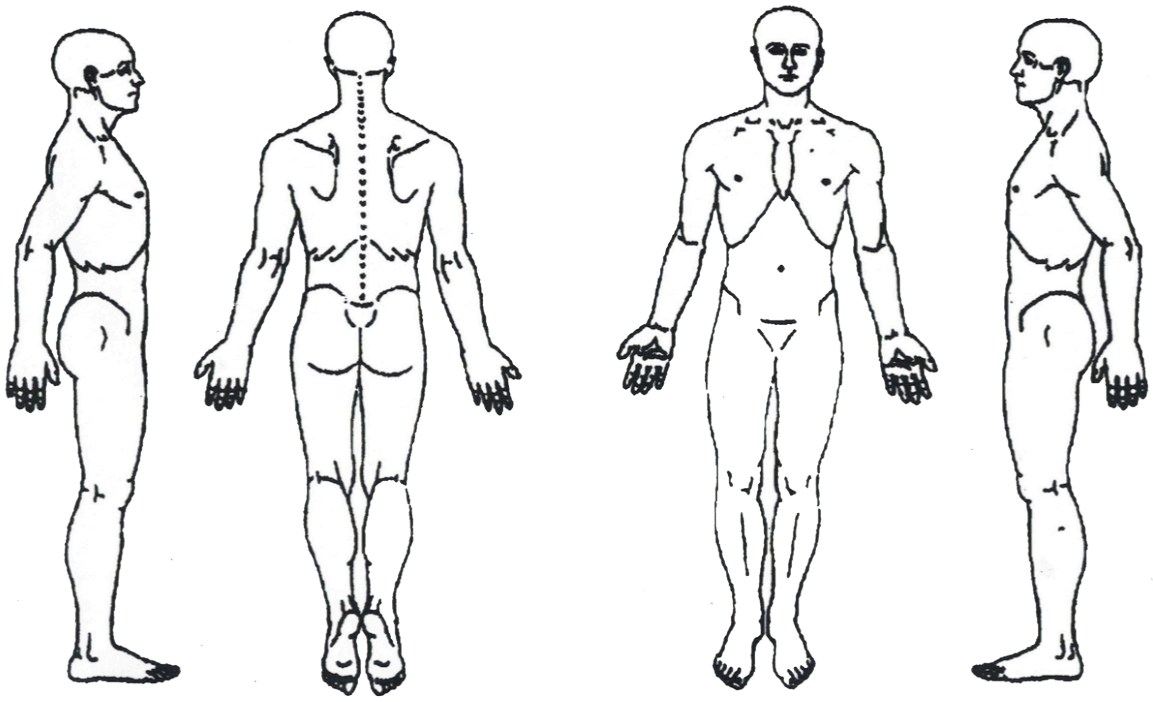
PAIN DIAGRAM

Mark the area on the diagram below that conincide with your pain. Include all the affected areas.
Use the individual letters to indicate pain description (A, B, N, S, or T) and then the number to describe your pain intensity.
(Example A-8). You may draw lines and point to the body if you need more space.

A - Aching B - Burning N – Numbness S - Stabbing T - Throbbing

No Pain	Mild Pain				Moderate Pain		Severe Pain		Worst Pain	
0	1	2	3	4	5	6	7	8	9	10



ADDITIONAL COMMENTS

Thank you for your time and effort. We look forward to providing you with the best possible care.