



This is a **CONFIDENTIAL** questionnaire to help us determine the best treatment plan for you.
Please print clearly. If you have questions, please ask our clinic staff. Thank you.

PERSONAL INFORMATION

** FOR PATIENT PROFILE EASY CHECK IN AND SCHEDULING

NAME** _____ DATE _____

HOME ADDRESS** _____

CITY ** _____ STATE** _____ ZIP ** _____

OCCUPATION _____ PHONE** _____

EMAIL** _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

EMERGENCY CONTACT NUMBER _____

HOW YOU HEARD OF US _____

HEIGHT: _____ WEIGHT: _____ BIOLOGICAL SEX: M F

BIRTH DATE: _____ AGE: _____

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED PARTNERED

NUMBER OF CHILDREN _____

HAD ACUPUNCTURE BEFORE? YES NO LAST TREATMENT _____

CAN WE SEND NOTIFICATION OR MESSAGES THROUGH? TEXT EMAIL VOICEMAIL

PHYSICIAN HISTORY

HAVE YOU SEEN A PHYSICIAN IN THE LAST YEAR? YES NO

PHYSICIAN'S NAME: _____ PHONE: _____

APPROXIMATE DATE/MONTH OF MOST RECENT EXAMINATION/VISIT? _____

PLEASE INDICATE ANY SIGNIFICANT ILLNESS YOU OR A BLOOD RELATIVE (GRANDPARENT, PARENT, OR SIBLING) HAVE HAD:

ILLNESS	YOU	RELATIVE	WHEN?	ADDITIONAL DETAILS
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
EMOTIONAL DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
FAINTING	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

STROKE _____
TUBERCULOSIS _____

SEXUALLY TRANSMITTED DISEASE:

GONORRHEA SYPHILIS HIV CHLAMYDIA HERPIES

PLEASE INDICATE THE USE AND FREQUENCY OF THE FOLLOWING:

	YES	NO	AMOUNT		YES	NO	AMOUNT
ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	_____	VAPING	<input type="checkbox"/>	<input type="checkbox"/>	_____
COFFEE	<input type="checkbox"/>	<input type="checkbox"/>	_____	SMOKING	<input type="checkbox"/>	<input type="checkbox"/>	_____
CAFFEINATED TEA	<input type="checkbox"/>	<input type="checkbox"/>	_____	COCAINE	<input type="checkbox"/>	<input type="checkbox"/>	_____
JUICE	<input type="checkbox"/>	<input type="checkbox"/>	_____	CANNABIS (SMOKE)	<input type="checkbox"/>	<input type="checkbox"/>	_____
WATER	<input type="checkbox"/>	<input type="checkbox"/>	_____	EDIBLES	<input type="checkbox"/>	<input type="checkbox"/>	_____
SODA	<input type="checkbox"/>	<input type="checkbox"/>	_____	RECREATIONAL DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	_____
TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>	_____				

HOW LONG SCREEN TIME PER DAY (COMPUTER/PHONE/TABLET):

< 1 HOUR 1-2 HOURS 2-4 HOURS 4-6 HOURS
 6-8 HOUR 8-10 HOURS + 10 HOURS

EXERCISE REGULARLY? YES NO

WHAT KIND OF EXERCISE (INCLUDING WALKS WITH PETS/ WORK/HOME):

HOW MANY TIMES A WEEK EXERCISE?












NONE 1DAY 2 DAY 3 DAYS 4 DAYS 5 DAYS 6 DAYS
 7 DAYS OTHER _____

PLEASE CHECK THE BOX IF ANY OF THE FOLLOWING STATEMENTS ARE TRUE:












I HAVE A PACEMAKER: YES NO
I AM TAKING COUMADIN/ WARFARIN/ PLAVIX: YES NO

WHAT ARE THE MAIN HEALTH PROBLEM FOR WHICH YOU ARE SEEKING TREATMENT?

HOW SEVERE IS IT TODAY? (10 IS THE WORST)

										
0	1	2	3	4	5	6	7	8	9	10

HOW SEVERE CAN IT GET THROUGHOUT THE WEEK? (10 IS THE WORST)

										
0	1	2	3	4	5	6	7	8	9	10

HOW LONG DID YOU HAVE THIS ISSUE?

WHAT OTHER FORMS OF TREATMENT HAVE YOU TRIED?

WHAT ARE YOUR GOALS YOU WOULD LIKE TO REACH FOR YOU MAIN HEALTH PROBLEMS?

LIST OTHER HEALTH PROBLEM YOU WOULD LIKE TO ADDRESS:

LIST ANY ALLERGIES, FOOD SENSITIVITIES:

LIST ANY FOOD CRAVINGS YOU MAY HAVE:

LIST ANY ACCIDENTS, SURGERIES, OR HOSPITALIZATIONS WITH DATE:

FOR FEMALE

AGE OF 1ST PERIOD (MENARCHE) _____ **DATE OF LAST PERIOD** _____

AGE OF LAST PERIOD (MENOPAUSE) _____

DATE OF LAST GYNECOLOGICAL EXAM _____ **PAP SMEAR** _____

DID YOU HAVE A HYSTERECTOMY? YES NO **WAS IT** FULL? OR PARITAL?

ARE YOU PREGNANT? YES NO **ARE YOU TRYING TO GET PREGNANT?** YES NO

HOW LONG HAVE YOU AND YOUR PARTNER HAVE BEEN TRYING TO CONCEIVE?

Have you had any:	Yes	No	How Many?	At What Age(s)?
Pregnancies?				
Children?				
Live Births?				
Abortions?				
Miscarriages?				
C-Sections?				
D&C?				
Breast Lumps?				
Abnormal Pap Smear?				

ARE YOU ON BIRTH CONTROL OR CONTRACEPTIVES? YES NO

WHAT METHODS OF BIRTH CONTROL OR CONTRACEPTIVES?

PILL if so what kind: _____

IMPLANT if so what kind: _____

IUD (COPPER)

DEPO-PROVERA

PATCH

IUD (HORMONAL)

INJECTION

VAGINAL RING

NUMBER OF DAYS BETWEEN PERIODS? _____ **NUMBER OF DAYS OF BLEEDING?** _____

DO YOU SPOT BETWEEN PERIODS? YES NO

DO YOU HAVE CLOTS?: YES NO

HOW HEAVY IS YOUR BLEEDING?:

HEAVY												
NORMAL												
LIGHT												
DAY	1	2	3	4	5	6	7	8	9	10	11	12+

WHAT IS THE COLOR OF BLOOD ? (MAKE "X" BELOW):

LIGHT RED	BRIGHT RED	ORANGE	DARK RED	PURPLE	BROWN	BLACK

HAVE YOU BEEN DIAGNOSED WITH:

- | | |
|---|--|
| <input type="checkbox"/> ADHESIONS | <input type="checkbox"/> ENDOMETRIOSIS |
| <input type="checkbox"/> FIBROIDS | <input type="checkbox"/> OVARIAN CYST |
| <input type="checkbox"/> FIBROCYSTIC BREASTS | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> PID | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> PELVIC ABNORMALITIES | |

ANY PREMENSTRUAL SYNDROME (PMS)? YES NO

NATURE OF PMS?	YES	NO	BEFORE	DURING	AFTER
CRAMPING PAIN					
STABBING PAIN					
BURNING PAIN					
DULL PAIN					
ACHING PAIN					
CONSISTENT PAIN					
BLOATING					
BEARING DOWN SENSATION					
BREAST TENDERNESS					
IRRITABLE					

OTHER SYMPTOMS RELATED TO MENSTRUAL CYCLE?

- DISCHARGE VAGINAL DRYNESS HEADACHE NAUSEA
- DIARRHEA CONSTIPATION MOOD SWINGS SWOLLEN BREASTS
- HOT FLASHES INSOMNIA NIGHT SWEATS POOR APPETITE
- INCREASED LIBIDO DECREASED LIBIDO
- VAGINAL ODOR INCREASED BODY ODOR
- OTHER _____

MENOPAUSE SYMPTOMS ?

- DISCHARGE VAGINAL DRYNESS HEADACHE NAUSEA
- DIARRHEA CONSTIPATION MOOD SWINGS SWOLLEN BREASTS
- HOT FLASHES INSOMNIA NIGHT SWEATS POOR APPETITE
- BRAIN FOG SKIN DRYNESS BRITTLE HAIR BRITTLE NAILS
- INCREASED LIBIDO DECREASED LIBIDO
- WEIGHT GAIN WEIGHT LOSS MEMORY LOSS
- URINARY URGENCY URINARY INCONTINENCE JOINT PAIN
- OTHER _____

FOR MEN

DATE OF LAST PROSTATE CHECK UP _____

FREQUENCY OF URINATION: DAYTIME _____ NIGHTTIME _____

COLOR OF URINE: CLEAR MURKY ODOR: _____

ANY LAB RESULT/DIAGNOSIS:

ANY ACCIDENTS/TRAUMA:

SYMPTOMS RELATED TO PROSTATE

- | | |
|--|---|
| <input type="checkbox"/> PROSTATE PROBLEMS | <input type="checkbox"/> DELAYED STREAM |
| <input type="checkbox"/> DRIBBLING | <input type="checkbox"/> INCONTINENCE |
| <input type="checkbox"/> RETENTION OF URINE | <input type="checkbox"/> RECTAL DYSFUNCTION |
| <input type="checkbox"/> INCREASED LIBIDO | <input type="checkbox"/> DECREASED LIBIDO |
| <input type="checkbox"/> PREMATURE EJACULATION | <input type="checkbox"/> IMPOTENCE |
| <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> GROIN PAIN |
| <input type="checkbox"/> TESTICULAR PAIN | <input type="checkbox"/> OTHER _____ |

HAVE YOU HAD A VASECTOMY? YES NO

REVERSED VASECTOMY? YES NO

HAVE YOU EVER BEEN DIAGNOSED WITH VARICOCELE? YES NO

ANY UROLOGIC SURGIES? YES NO

ANY PENILE DISCHARGE? YES NO

ARE YOU AND YOUR PARTNER TRYING TO GET PREGNANT? YES NO

HOW LONG HAVE YOU AND YOUR PARTNER HAVE BEEN TRYING TO CONCEIVE? _____

IF SO, HAVE YOU BEEN CHECKED? YES NO

HOW IS YOUR SEXUAL ENERGY? LOW NORMAL HIGH

SPERM COUNT? BELOW NORMAL NORMAL

SPERM MOTILITY? BELOW NORMAL NORMAL

SPERM MORPHOLOGY? SPERM COUNT BELOW NORMAL NORMAL

SYMPTOMS SURVEY FOR EVERYONE

Its is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms, thus, it is essential to indicate time on the symptoms.

NO MARK () - NEVER

CHECK MARK (✓) = SOMETIMES

PLUS SIGN (+) = FREQUENTLY

General

- Poor Appetite
- Strong Appetite
- Fever
- Insomnia/Difficult Sleeping
- Heavy Sleep
- Sleep Apnea
- Fatigue
- Cold sensation in Abdomen
- Cold sensation in Hands/Feet
- Cold sensation in Back
- Cold sensation in Genital
- Chills
- Spontaneous Sweat
- Night Sweats
- Strong Thirst
- Easily Bruise
- Easily Bleed
- Varicose/Spider Veins
- Vertigo/Dizziness

Skin/Hair

- Rashes
- Itching
- Hives
- Acnes
- Eczema
- Purpura
- Ulceration
- Dandruff
- Hair loss/ Thinning
- Soft/Brittle Nails
- Jaundice (yellow eye/skin)

Head/ Eyes/ Ears/ Nose/ Throat

- Concussion
- Migraines
- Headaches
- Eye strain
- Eye pain
- Poor vision
- Color Blindness
- Glasses
- Night Blindness
- Cataracts
- Eye Floaters/Spots
- Facial Pain
- Dry Mouth

- Grinding Teeth
- Teeth Problem
- Jaw Click
- Ringing in Ear/Tinnitus
- Poor hearing/Impairment
- Nose Bleeds
- Hayfever
- Decrease sense of smell
- Dry Mouth/ Throat
- Excessive Mucus/Saliva
- Ear Aches

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Blood clots
- Difficult to stop bleeding
- Fainting
- Irregular Heart
- Swollen Hand/ feet/ Edema
- Chest tightness
- Angina Pain
- Rapid Heart Beat /Palpitation

Respiratory

- Coughing Blood
- Asthma
- Allergies
- Bronchitis
- Pneumonia
- Difficult breathing when lying down
- Catch cold easily
- Chronic Cough
- Production of Phlegm
- Difficulty Breathing
- Shortness of Breath
- Nasal/Sinus Issues

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Hemorrhoids
- Colitis/ Diveticulitis
- Belching/ Burping
- Bad Breath
- Rectal Pain
- Constipation
- Gallstones

- Indigestion
- Heartburn
- Acid Reflux
- Tan/Light Stool
- Bloody Stool
- Black tarry stool
- Sensitive to touch abdomen
- High Cholesterol
- Sudden weight loss
- Sudden weight gain
- Hard to digest

Bladder/Urinary

- Pain urinating
- Frequent urination
- Incontinence
- Blood in urine
- Kidney stones
- Dribbling Urination
- Strain sensation urinating

Musculoskeletal

- Neck Pain
- Back pain
- Chest Pain
- Ribcage pain
- Knee Pain
- Foot Pain
- Joint pain
- Muscle weakness
- Spasm or twitching of muscles
- Pain with weather changes

Neuropsychological

- Poor Memory
 - Nightmares
 - Mental Restlessness
 - Seizures
 - Areas of Numbness
- Emotions/Mental**
- Anxiety
 - Anger/Agitated Easily
 - Easily Stressed
 - Depression
 - Feeling Claustrophobia
 - Tendency to become obsessive in work/relationship
 - Difficult making plans/decisions
 - Considered/Attempted Suicide

Patient Acknowledgment of Information Accuracy

I certify that the information I have provided in this intake form is true, complete, and accurate to the best of my knowledge.

I understand that providing accurate health information is important for my safety and the effectiveness of my treatment.

I have disclosed all relevant medical history, including but not limited to:

- Past and current medical conditions
- Surgeries and procedures
- Medications and supplements
- Injuries, trauma, or accidents
- Allergies or sensitivities

I understand that failure to provide complete or accurate information may increase the risk of adverse reactions or complications, and I accept responsibility for any outcomes related to omitted or inaccurate information.

I agree to inform my practitioner of any changes in my health status, medications, or medical care.

Patient Name (Print)

Patient Signature & Date