Scottsdale Acupuncture & Alternative Medicine

This is a confidential intake form. Please fill out completely to help us better diagnose you properly so we may come up with the best treatment plan for you.

Name____**Date**__________________________

Address____

City____________________________**State**_________________**Zip**________________________

Hm Phone______________________________ **Cell**_____________________________________

Birthdate_________________**Height**________**Weight**______**Referred by**________________

Email Address:____

(used only for apt confirmations/reminders and 4 newsletters/announcements per year)

Reason for visit:____

How long have you had this condition?_____________**What makes it better?**___________

What makes it worse?____________________**Is your condition getting better or worse?**

Medications you are currently taking:____

____

Supplements you are currently taking:____

____

List surgeries/operations you have and the dates:_________________________________

____

Medical History: Do you have or have you ever had (please circle)
Arthritis Asthma Anemia High Blood Pressure Cancer Chronic Fatigue Diabetes Epilepsy
Gallstones Hepatitis Hypo/Hyper Thyroid Sudden Weight Loss/Gain
Other:____

Energy Level: High (time of day)____________________Low (time of day)_________________
Stress: Low Moderate Severe What causes it?_______________________________________
Sweating: Night Sweats Rarely Sweat Excess Sweating
Circulation: Feel Cold Easily Get Hot Easily What Areas?______________________________
Skin/Hair: (Please Circle)
Dry Itchy Moist/Clammy Burning Boils Rashes Acne Puffy Skin Bruises Easily
Hair Loss/Thinning Dry Scalp Dandruff Psoriasis **Other:**_____________________________
List Major Scars: (from accidents/surgeries ____

____

Please Circle those that apply

Sleep: Trouble Falling Asleep Trouble Staying Asleep Restful Excess Dreaming **Hrs of sleep**__
Head: Headaches (what area?)_________________ Dizziness Memory Loss Loss of Balance
Eyes: Eye Pain Dry Eyes Blurred Vision Dark Circles Floaters **Other:**_________________
Ears: Poor Hearing Earaches Discharge Infections Ringing or Buzzing in Ears
Nose: Nose Bleeds Sinus Infections Frequent Colds Runny Nose
Throat: Difficulty Swallowing TMJ History of Strep Frequent Sore Throat Post Nasal Drip

Chest: Shortness of Breath Heart Palpitations Persistent Cough Pain or Pressure in Chest
Blood Pressure: High Low Do Not Know Normal Other:___________________________
Bowels: Diarrhea Constipation Bloody Stools Hemorrhoids Gas # of BM's daily_______
Urination: Frequent Retention Painful Difficult Blood in Urine Night Time Urination UTI

Musculoskeletal Pain/Issues: Neck Shoulders Upper Back Mid Back Low Back Hip
Legs Knees Arms/Hands Ankles Feet Muscles Spasms Joint Pain (where)_______________
Loss of grip Leg cramps Weakness (where)_________________ Numbness or Tingling_______

Neurological: Nervousness Depressed Anxiety Frustration Anger Irritability Mood Swings
Frequent Crying Memory Loss Poor Concentration Suicidal Thoughts Tremors Seizures
Nerve Pain Shingles **Other:**____

Females: Pregnant Not Pregnant Last Monthly Period__________ Last PAP_______________
Form of Birth Control___________________ Age Started Menses______ Aged Stopped_________
Menstrual Pain Low Back Pain Irregular Cycles Clotting Heavy Bleeding Light Bleeding
Water Retention Mood Swings Missed Periods Painful Breasts Hot Flashes Severe Cramps
Food Cravings Before Cycle (if so, what?) ____
Operations: Cervix Uterus Ovaries Other:________________________High/Low/No Sex Drive
Number of Pregnancies:_____ # of Deliveries_____# of Cesareans____ # of Miscarriages_____
# of Abortions____ Complications:____

Males: Low Sex Drive No Sex Drive High Sex Drive Impotence Pain Discharges
Premature Ejaculation Enlarged Prostate Frequent Urination Other:_______________________

**** Do you have surgical implants of any kind?** If so what?_______________________________

Appetite: Excessive Appetite Low Appetite Appetite Changes Feel Tired if Meal is Missed
Excessive Thirst Never Thirsty **Food Cravings:** Sweet Salty Sour **Other:**_______________
Digestion: Stomach Pain Bloating Gas Heartburn Belching Nausea Vomiting Canker Sores
Bad Breath Weight Gain Weigh Loss Slow Metabolism Fast Metabolism Gurgling Stomach
Food Allergies: Gluten Sensitive/Intolerant Lactose Intolerant Nut Allergy (what)____________
Other food sensitivities or allergies____

Nutrition: List your Typical Breakfast____
Typical Lunch____
Typical Dinner____
Snacks____

How Much Water do you Consume in a Day?________________ Filtered/Bottled/Tap/Sparkling
Do you Consume Alcohol? Yes No Amount Per Week__________ Type___________________
Tobacco: Yes No # of packs/cigarettes per day______________ How Many Years____________
Caffeine: Coffee Soda Tea Energy drinks **How much?**________________________________

Do you eat raw fruits daily?	Y or N	Do you eat until full?	Y or N
Are you gluten free?	Y or N	Do you eat when not hungry?	Y or N
Are you dairy free?	Y or N	Do you do regular cleanses?	Y or N
Are you egg free?	Y or N	Do you eat processed food?	Y or N
Are you Vegetarian?	Y or N	Do you eat fast food?	Y or N
Are you Vegan?	Y or N	Do you go on crash diets?	Y or N
Do you consume Diet Drinks?	Y or N		
If so what kind?_________________		Do you use table salt or sea salt? (circle)	
Do you consume dairy?	Y or N		
If so what kind__________________		Do you have an eating disorder? Y or N	

Patient Signature______________________________________ ***Date***________________________