



**ADULT INTAKE FORM: ACUPUNCTURE AND CHINESE MEDICINE**

**DATE:** \_\_\_\_\_.

**LAST NAME:** \_\_\_\_\_ **FIRST\MIDDLE NAME:** \_\_\_\_\_.

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_.

**ADDRESS:** \_\_\_\_\_.

**PHONE NUMBER:HOME** \_\_\_\_\_ **WORK** \_\_\_\_\_.

**EMAIL:** \_\_\_\_\_.

**EMRGENCY CONTACT (NAME AND PHONE NUMBER):** \_\_\_\_\_

**FAMILY DOCTOR** \_\_\_\_\_ **PHONE NUMBER** \_\_\_\_\_.

**OTHER PRACTITIONERS:** \_\_\_\_\_.

<b>HEALTH CONCERNS\HISTORY</b>	
<b>PLEASE LIST YOUR CONCERNS IN ORDER OF IMPORTANCE</b>	
<b>SINCE</b>	<b>CONCERN</b>

<b>ALLERGIES &amp; SENSITIVITIES</b>
<b>PLEASE LIST ANY KNOWN OR SUSPECTED ALLERGIES OR INTOLERANCE TO FOOD AND DRUGS</b>



**MEDICATIONS\SUPPLEMENTS\DRUGS**

**PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRNTLY TAKING INCLUDING PRESCRIPTION DRUGS, OVER THE COUNTER DRUGS, VITAMINS, MINERALS, HERB, HOMEOPATHIC, ETC.**


**PAST MEDICAL HISTORY**

CHICKEN POX		SCARLET FEVER		TONSILLITIS	
MEASLES		PNEUMONIA		EAR INFECTIONS	
MUMPS		FREQUENT COLD			
RUBELLA		RHEUMATIC FEVER			
OTHER					

**INJURIES,SURGERIES,HOSPITALIZATIONS**

**PLEASE LIST ANY PAST SERIOUS INJUREIS,SURGERIES AND HOSPITALIZATIONS**


**HAVE YOU HAD ANY ADVERSE REACTION TO ANY VACCINE? IF YES,PLEASE EXPLAIN**




<b>ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING CONDITIONS?</b>			
<i>Cold (body temp.)</i>		<i>Hot\cold (fluctuating)</i>	<i>Night sweats</i>
<i>Spontaneous sweating</i>		<i>Headaches</i>	<i>Dizziness</i>
<i>Palpitations</i>		<i>Intense emotions</i>	<i>Thirst</i>
<i>Tinnitus</i>		<i>Low back pain</i>	<i>Heartburn</i>
<i>Sleep disturbance</i>		<i>Shortness of breath</i>	<i>Weak knees</i>
<i>other</i>			

<b>FAMILY HISTORY</b>				
<b>RELATIVE</b>	<b>CURRENT AGE</b>	<b>or</b>	<b>AGE AT DEATH</b>	<b>ALIMENT</b>
<i>MOTHER</i>				
<i>FATHER</i>				
<i>BROTHERS</i>				
<i>SISTERS</i>				
<i>MATERNAL GRANDMOTHER</i>				
<i>MATERNAL GRANDFATHER</i>				
<i>PATERNAL GRANDMOTHER</i>				
<i>PATERNAL GRANDFATHER</i>				
<i>OTHER</i>				



<b>WEIGHT</b>
<b>HAVE YOU LOST OR GAINED ANY WEIGHT IN THE LAST 6 MONTHS? YES_NO_.</b>
<b>HOW MANY? _____Lbs\Kgs</b>
<b>PHYSICAL ACTIVITY</b>
<b>ARE YOU PHYSICALLY ACTIVE? YES____NO____.</b>
<b>IF YES, DESCRIBE AND INDICATE HOW MUCH DURING A TYPICAL WEEK</b>
_____.
<b>HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING PER WEEK?</b>
<b>COFFEE_____.</b>
<b>TOBACCO_____.</b>
<b>ALCOHOL_____.</b>
<b>RECREATIONAL DRUGS_____.</b>
<b>SODA\POP_____.</b>

<b>HAVE YOU NOTICED ANY GENERAL TRENDS WITH RESPECT TO YOUR HEALTH? (E.g. get sick easier or not as much, it is easier or not to get a restful sleep, muscles feeling stronger or weaker, more or less energy, etc. If yes please explain.</b>
_____
_____
_____
_____
_____
<b>HAVE YOU HAD ANY MINOR OR MAJOR CONDITIONS, AFTER WHICH, YOU FELT YOU HAVE NEVER FULLY RECOVERED? IF YES, PLEASE EXPLAIN.</b>
_____
_____
_____
_____
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