Lori Brown, MSOM

Medical Intake Form

Date_____

Name_____

Address_____

Phone _____ Email _____

Emergency Contact Name/ Phone _____

Age _____ Birthdate _____ Height_____ Weight_____

Do you have high blood pressure? _____

If yes, is blood pressure being controlled by medication? _____

Usual Blood Pressure _____ Do you have a pacemaker? _____

Main Health Concerns You Would Like Help With

Please list each condition and how long you have experienced it

1._____

2._____

3._____

What other types of treatments have you tried? _____

_____

What types of medicines and supplements are you currently taking?

Please include all medications, vitamins, herbs, etc. _____

_____

Are you on a special diet? _____

List any allergies _____

Areas of Pain _____

Daily Habits- Number Per Day

Cigarettes _____ Alcoholic Drinks_____ Sodas _____

Caffeinated Drinks (coffee, cola, black tea, etc.) _____ Energy Drinks_____

Do you currently use illegal drugs? _____

Occupation _____

Hobbies/Activities/Types of Exercise and how many times per week

_____

Past Medical History

Please list any past medical conditions such as cancer, kidney stones etc.

_____

Surgeries_____

Previous injuries _____

Current Health Conditions

Have you been diagnosed with or do you experience any of the following?

Cancer Diabetes
HIV/AIDS

Addiction- Any Kind Heart Disease Hepatitis

High Blood Pressure Liver Disease Seizures

Kidney Disease Fainting
Infection

Any other health conditions? _____

Women Only

Age of Onset of Menses_____ Days in Cycle (28?) _____

Number of Days of Bleeding _____ Date of Last Period _____

Unusual Vaginal Discharge? _____ Vaginal Dryness? _____

Please circle any of the following that apply to the quality of menses

Thick Thin Clots Bright Color Dark Color Pale Color

Number of Pregnancies _____ Number of Births _____

Birth Control Type _____ PMS Symptoms? _____

General Health Imbalances

Please Circle All That Apply

Poor Appetite Cravings Constipation Diarrhea Nausea Gas

Vomiting Gas Belching Bad Breath Abdominal Pain/Cramping

Bloody Stools Rectal Pain Acid Reflux Hemorrhoids

Abdominal Fullness/Bloating Undigested Food in Stool

Daily Bowel Movements… Soft Normal Hard Number per Day ____

Pain During Urination Inability to Hold Urine Frequent Urination

Waking at Night to Urinate Kidney Stones Blood in Urine

Impotence/Infertility Genital Sores Genital Itching Venereal Disease

Sex Drive Too High Sex Drive Too Low Erectile Dysfunction

Weakness Insomnia Night Sweats Hot Flashes Cold Hands/Feet

Fatigue Bleed / Bruise Easily Prefer hot drinks Prefer cold drinks

Prolapse Unusual Taste in the Mouth Chills Fever

Headaches Dizziness Tremor Seizures Heavy Sensation in the Head

Sinus Problems Memory Loss Speech Problems

Rashes Eczema Acne Hives Itching Dandruff
Dry Skin

Hair Loss Dry Mouth Dry Throat

Eye Strain Eye Pain Dry Eyes Spots/Floaters Near/Far Sightedness

Night Blindness Cataracts Scratchy or Red Eyes

Tooth Pain Tooth Loss Grinding of Teeth Many Cavities

Bleeding Gums Sores in Mouth Ringing in Ears Hearing Loss

High Blood Pressure Low Blood Pressure Fainting Chest Pain

Irregular Heartbeat Heart Palpitations Unusual Sweating

Swelling of Hands or Feet

Cough Phlegm Coughing of Blood Asthma Difficulty Breathing

Bronchitis Chest Tightness Inability to Take a Deep Breath

Aversion to Wind Catch Colds Easily Dryness of Respiratory Passages/Lungs

(Circle only if common, prolonged or severe)

Depression Anxiety Anger Stress Bad Temper Sadness

Desire to Be in Control Overthinking Fear Worry Nightmares

Difficulty in Making Decisions

Generalized Joint Pain Joint Pain Worse in Cold Weather Numbness

Joint Pain Worse in Damp Weather Burning Pain Limb Heaviness

Tight Muscles Spasms Atrophy Lax Joints Jaw Pain/Clicking

Joint Pain That Moves from One Location to Another

I will inform my acupuncturist if I am or become pregnant prior to treatment as some treatments and herbal formulas may not be suitable for pregnancy. I also agree to keep my acupuncturist informed of any changes to my health or medical care prior to each treatment so that my medical information can be updated.

Patient (or legal guardian) Signature _____