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 ___________________________