# Patient Intake Form

Please take the time to fill this form out. It will help me to determine how best to treat you. Thank you!

Dina M. Singer, M.Ac., L.Ac.

## Patient Information

Name: _____ Date: _____

Sex: M F (circle one) Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone:

*Cell: _____

*Home: _____

*Work: _____

Which phone number is the best one to use to reach you? _____

Email Address: _____

Height: _____ Weight: _____ Occupation: _____

Emergency Contact/ relationship to you: _____

Emergency Contact telephone: _____

Name of physician*: _____

Physician telephone number: _____

Name of counselor/psychologist*: _____

Counselor/psychologist telephone number: _____
*No contact will be made without your permission.

**What has brought you to acupuncture?** Please list all concerns, issues, ailments or conditions that you would like to address during treatment.

_____

_____

_____

_____

_____

**Personal lifestyle habits:** For each item, please indicate how much, how many or how often. Please note if this is current of the date that you quit.

Cigarettes (single or packs per day): _____

Alcohol (drinks per week): _____

Drug use (recreational): _____

Coffee/Tea (cups per day): _____

Soda (regular or diet) (how many per day): _____

Exercise: Yes or No and how often: _____

What kind of exercise? _____

**Medical:** If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list them below along with the year and hospital.

1. _____

2. _____

3. _____

4. _____

**Medications, vitamins, and supplements:** Please list all medications, vitamins and/or food supplements you are currently taking.
***Please indicate dosage and reason/for what condition.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

## CURRENT AND PAST CONDITINS/SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experienced the condition both in the past and currently.

**General**

____ Insomnia
____ Dreams/nightmares
____ Fatigue
____ Poor memory
____ Strongly like cold drinks
____ Strongly like hot drinks
____ Recent weight loss/gain
____ Cold hands & feet
____ Chills
____ Fever
____ Bad breath
____ Other (describe)
_____

**Head & Neck**

____ Headaches
____ Migraines
____ Stiff neck
____ Dizziness
____ Fainting
____ Swollen glands
____ Other (describe)
_____

**Ears**

____ Ringing
____ Hearing loss
____ Hearing aids
____ Infections
____ Earache
____ Vertigo
____ Other (describe)
_____

**Eyes**

____ Glasses/contact lenses
____ Blurred vision
____ Poor night vision
____ Spots or floaters
____ Double vision
____ Glaucoma
____ Cataracts
____ "Lazy" eye
____ Other (describe)
_____
____ How often checked?
_____

**Nose, Throat & Mouth**

____ Sinus infection
____ Hay fever/ allergies
____ Frequent sore throat
____ Difficulty swallowing
____ Mouth & tongue ulcers
____ Frequent colds
____ Nosebleed
____ Dry Nose
____ Nasal congestion
____ Loss of voice
____ Thirst
____ Excessive phlegm
____ TMJ
____ Facial pain
____ Gum problems
____ Dry mouth
____ Other (describe)
_____
____ Dental problems? Last visit:
_____

**Skin**

____ Hives
____ Rashes
____ Eczema/psoriasis
____ Night sweating
____ Excess sweating
____ Dry skin
____ Easily bruised
____ Changes in moles, lumps
____ Itching
____ Other (describe)
_____

**Respiratory**

____ Difficulty breathing
____ Difficulty breathing when reclining
____Wheezing
____ Asthma
____ Chronic cough
____ Wet cough
____ Dry cough
____ Coughing up phlegm
____ Coughing up blood
____ Shortness of breath
____ Tight chest
____ Pneumonia
____ Other (describe)
_____

**Cardiovascular**

____ High blood pressure
____ Low blood pressure
____ Chest pain or tightness
____ Palpitation
____ Rapid heart beat
____ Poor circulation
____ Swollen ankles
____ Phlebitis
____ Anemia
____ History of heart disease
____ Heart murmur
____ Night sweats
____ Tendency to be cold
____ Tendency to be warm
____ Other (describe)
_____

**Gastrointestinal**

____ Nausea
____ Indigestion
____ Stomach pain
____ Diarrhea
____ Constipation
____ Poor appetite
____ Excessive hunger
____ Vomiting
____ Gas
____ Hiccups
____ Acid regurgitation
____ Bloating
____ Laxative use
____ Bloody stool
____ Other (describe)
_____

**Musculoskeletal**

____ Joint pain/swelling
____ Sore muscles
____ Weak muscles
____ Difficulty walking
____ Pain (describe)
_____
_____
_____
____ Limited range of motion
____ Other (describe)
_____

**Neurological**
____ Seizures
____ Tremors
____ Numbness or tingling
____ Pain (describe)
_____
____ Paralysis
____ Poor coordination
____ Other (describe)
_____

**Mental/Emotional**
____ Depression
____ Moodswings
____ Irritability
____ Difficulty relaxing
____ Loneliness
____ Sensitive
____ Shyness
____ Frequent crying
____ Worries frequently
____ Hopeless outlook
____ Lose temper
____ Frustration
____ Other (describe)
_____

**Urinary**
____ Pain on urination
____ Frequent urination
____ Urgent urination
____ Blood in urine
____ Incontinence
____ Incomplete urination
____ Bedwetting
____ Wake to urinate
____ History of URI
____ Kidney (specity)
_____
_____
____ Other (describe)
_____

**Male Genital**
____ Impotence
____ Premature ejaculation
____ Nocturnal emission
____ Pain/itching of genitalia
____ Lumps in testicles
____ Increased libido
____ Decreased libido
____ Breast checked
____ Other (describe)
_____

**Gynecology (Women Only)**
____ Currently pregnant
____ # of Pregnancies
____ # of Live births
____ # of Miscarriages
____ # of Abortions
____ Menopause
____ Irregular periods
____ Menstrual cramps
____ Excessive blood flow
____ Menstrual blood clots
____ Breast tenderness
____ Abnormal pap smear
____ Vaginal infections
____ Vaginal pain/itching
____ Uterine fibroids
____ Endometriosis
____ Breast lumps, cysts
____ Increased libido
____ Decreased libido
____ Other (describe)
_____

**Infection Screening** (circle self and/or partner)
____ HIV risks: self or partner
____ TB: self or household
____ Hepatitis risk: self or partner
____ History of sexually transmitted disease: self or partner (specify)
_____
_____
____ Other (describe)
_____

**Trauma** (list)
_____
_____
_____

**Other Information**
_____
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_____
Patient Signature

_____
Date

Date Revised: 11/10