Owen McPeake Acupuncture

Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION

Practitioner _____

Name _____ Sex ❑ M ❑ F Date _____

Address _____ City_____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

Date of Birth _____ Age _____ Email _____

❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Separated/Divorced

Height _____ Weight _____ Occupation _____

Education _____

Emergency contact _____ Relation _____

Emergency contact telephone: Home _____ Cell _____

Name of physician* _____ Phone number _____

Address _____ City_____ State _____ Zip _____

Name of counselor/psychologist* _____ Phone number _____

Address _____ City_____ State _____ Zip _____

Name of gynecologist* _____ Phone number _____

Address _____ City_____ State _____ Zip _____

* No contact will be made without your permission.

Your signature _____

Special problems or symptoms _____

_____

_____

_____

– over –

FAMILY HISTORY Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
Good health						
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure/heart disease/stroke						
Blood or bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Deceased (age)	N/A					

PERSONAL LIFESTYLE HABITS For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs per day) _____
Alcohol (drinks per week) _____
Drug use (recreational) _____

Coffee/Tea (cups per day) _____
Soda (regular or diet) _____
Exercise ❑ Yes ❑ No How often? _____
What kind of excercise? _____

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS	HOSPITAL OR TREATMENT LOCATION

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications _____ Dosage _____ For what condition? _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Vitamins _____ Dosage _____ For what condition? _____
_____ _____ _____
_____ _____ _____

Food Supplements _____ For what condition? _____
_____ _____
_____ _____
_____ _____

CURRENT AND PAST CONDITIONS/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
_____ Eye inflammation
_____ 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
_____ Irregular 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)

_____

– over –

Neurological

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

_____

Mental/Emotional

_____ Depression
_____ Mood swings
_____ Irritability
_____ Difficulty relaxing
_____ Loneliness
_____ Sensitive
_____ Shyness
_____ Frequent crying
_____ Worries frequently
_____ Compulsive behaviors
_____ Difficulty focusing
_____ Hopeless outlook
_____ Suicidal thoughts
_____ 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 UTI
_____ Kidney (specify)

_____

_____

_____ 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