Acupuncture and Oriental Medicine

Intake Form

Note: Information provided on this form is confidential

Please print legibly Today's Date: _____/_____/_____

Name: _____ Age: _____ Sex: M: ____ F: _____ Date of Birth: _____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

E-Mail Address: _____ Cell Phone: (_____) _____-_____

Emergency contact: _____ Phone No.: (_____)_____-_____ Occupation: _____

Referred by: _____ Primary care physician: _____ Phone No.: _____

Have you ever been treated with Acupuncture, Chinese Herbs, Bodywork? _____ If yes, what condition and by whom (include phone number): _____

What is the purpose of your visit?: _____

How long have had this condition?: _____ Was the onset sudden or gradual?: _____

Symptoms are relieved by: _____ Symptoms are made worse by: _____

What medical diagnosis have you received?: _____

What other treatments have you received recently for this and/or other conditions?: _____

_____

List all medications taken within the last two (2) months (include vitamins, over the counter drugs, herbs, etc.:

_____

_____

For what conditions are you taking medications?: _____

In general, do you usually feel hot or cold?: _____ Do you often have chills or fever?: _____

Past Medical History:

Please check all of these conditions that apply:

____ AIDS/HIV	____Cancer	____Lyme Disease	____Seizures
____Alcoholism	____Diabetes	____Multiple Sclerosis	____Tuberculis
____Allergies	____Emphysema	____Pacemaker	____Asthma
____Heart Disease	____Polio	____Lymph Nodes removed	____Birth Trauma
____Hepatitis A/B/C	____Rheumatic Fever	____Herpes I / II	____Scarlet Fever
____Epstein Bar Virus	____Mononucliosis	____Cyclo Megla Virus	____Prosthetics

____Implants Other:_____

List all allergies: _____

Describe any significant injuries, surgeries, or major illnesses, whether hospitalized or not, and the dates:

_____

_____

Are you pregnant?: _____ If yes, how many months : _____ Are you presently trying to get pregnant?: _____

Diet and Food:

How is your appetite? _____

Do you have any specific food cravings? _____

Describe meals for a typical day: Breakfast: _____

Lunch: _____

Dinner: _____

How often do you have? Meat: _____ day/wk Coffee or Tea (caffeinated): _____ day/wk Sugar/Sweet: _____

Dairy (milk, cheese, yogurt): _____ day/wk. Wheat (wheat products): _____ day/wk

Are you always thirsty?: Yes:____ No: ____ Do you prefer hot or cold drinks?: _____ Alcohol: _____ day/wk

How many cups/glasses do you have daily?: Water: ____ Soda: ____ Coffee/Tea: ____

Rate your taste preference 1 to 5 (1: like most to 5: dislike):

Salty: _____ Sour: _____ Bitter: _____ Spicy: _____

Gastrointestinal (GI) Profile:

Check all that apply: Bloating:_____ Acid regurgitation:_____ Heartburn:_____ Belching:_____ Vomiting:_____

Blood in urine:_____ Blood in feces:_____ Stomach Ulcers:_____ Hernia:_____ Indigestion:_____ Stomach pains:_____

Hemorrhoids: _____ Bowel movements: How often? _____day/wk Do you frequently have painful bowel movements?:____

Irregular Bowel movements: _____ Constipation: _____Diarrhea: _____ Gas: _____ Use laxatives: _____

Undigested food in stool: _____ Loose stool: _____ Hard stools: _____ Itchiness: _____ Other: _____

Exercise and Energy:

How is your energy level?: _____

What time of the day is your energy?: Highest: _____ Lowest: _____

Do you fatigue easily?: _____

What type of exercise do you participate in and how often?: _____

Emotions and Sleep:

How do you feel emotionally?: _____

How many hours of sleep do you get? _____

Do you have (check all that apply): Panic attacks: ____ Depression: ____ Anxiety: _____ Bad Temper: ____ Nervousness: ____

Poor memory: _____ Fear/Fright: _____ Difficulty concentrating: ____ Other: _____

Where do hold stress?: _____

How do you relax or reduce stress?: _____

How do you feel about your work or profession?: _____

How do you feel about your relationship with your spouse or significant other?: _____

_____

Do you use recreational drugs?: _____ If yes, what substance (s)?: _____

How many hours of sleep do you normally get per night?: _____ Do have difficulty falling asleep?: _____ Staying asleep: _____

Urogenital:

How many times per day do you urinate?: _____ Color: Pale yellow: _____ Dark yellow/orange: _____

Check all that apply: Do you have trouble starting a stream: ___ Frequent urination: ___ Incontinence: ____ Pain on urination: ____

Urinary tract infection: _____ Dribbling when sneezing: ____ How is your sexual energy?: _____

What type of birth control do you use?: _____

Do you have (check all that apply)?: Infertility: ____ What was determined to be the cause of your infertility: _____

_____

Other: _____

Women:

Please indicate current or previous menstrual conditions even if now menopausal:

At what age did you start menstruating?: _____ Number of days between cycles: _____ Number of days of menstrual flow: _____

Color of flow: _____ **Check all that apply**: Irregular menstruation: ____ Heavy flow: ____ Light flow: ____ No flow: _____

Clots: _____ Vaginal itching/burning: _____ Spotting between periods: _____ Pain/discomfort before period: _____

Other: _____

Do you have and vaginal discharge?: _____ Amount: _____ Color: ____ Frequency: _____

Do you have any blood or mucous breast discharge?: _____ Amount: _____ Frequency: _____

PMS symptoms: _____

Menopausal symptoms: _____

Number of pregnancies: _____ Number of deliveries: _____ Abortion (s)/Miscarriage: _____

Men:

Check all that apply: Prostatitis: _____ Impotence: _____ Premature ejaculation: ____ Penile blood/mucous discharge: _____

Other: _____

Muscles, Joints, and Bones:

Do you have pain, tenderness, or tightness?: _____ If yes, where?: _____

Quality of pain: Sharp: ____ Aching: ___ Numb: ____ Deep: ____ Burning: ____ Dull: ____ Superficial: ____ Tingling: ___

Is your pain worse or better with heat or cold?: _____ Is your pain worse in the AM/PM: _____

Check all that apply: Swollen joints: ____ Arthritis/joint pain: ____ Tendonitis: ____ Rheumatism: _____ Bone pain: _____

Muscle pain: _____ Repetitive strain injury: _____ Other: _____

Pain Visual analog scale: Place an "X" on the line below that best rates your pain level on a scale of 1-10:

0_____10

Respiratory, Eyes, Ears, Nose, Throat, and Head:

Do you smoke?: _____ How many cigarettes per day?: _____ How long have you been smoking:? _____

Have you ever tried to quit?: _____ If yes, how many times?: _____ What method of quitting have you used: _____

Check all that apply: Frequent colds: _____ Chronic runny nose: ____ Post nasal drip: ____ Chronic cough: ____

Coughing up blood: _____ pain on inhalation: _____ Difficulty inhaling: ____ Difficulty exhaling: ____ Asthma: _____

Nose bleeds: ____ Painful/red eyes: ___ Poor vision: ___ Seeing spots: ___ Dizziness: ___ Cold sores: ____ Bleeding gums: ____

Dry mouth: ____ Frequent sore throat: ____ Coughing up mucous: ____ Color of mucous: ____ How much?: ____ Ear pain: ____

Clogged/Popping ears: ____ Ringing in the ears: ____ Frequent Headaches/migraines: ____ If yes, please where on your head the

Headaches/migraines manifests: _____ Describe further: _____

Other: _____

Cardiovascular:

Blood Pressure: _____/_____ Do you have a history of high blood pressure?: _____ Have ever been diagnosed with heart

trouble?: _____ Irregular heart beat: ____ Chest pain: ____ Palpitations: ____ Varicose veins: ____ Phlebitis: ____

Lymphedema: ____ Cold hands and feet: _____ poor circulation: _____ Other: _____

Skin and Hair:

Check all that apply: Dry skin:____ Rashes: ____ Itching: ____ Acne: ___ Eczema: ___ Hives: ___ Hair Loss: ___

Premature graying: ____ Other: _____

Family Medical History (Please list any significant family illness):

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Worksman's Compensation (WC) and Auto Accident Cases Only:

Date of Accident: _____

Diagnosis: _____

Insurance Company: _____

Address: _____

_____

Name of Insurance Adjuster: _____

Contact Phone number: _____

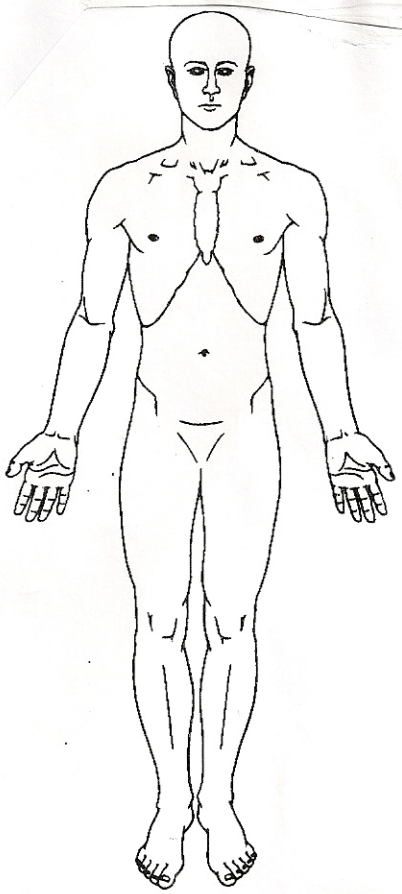
Claim number: _____

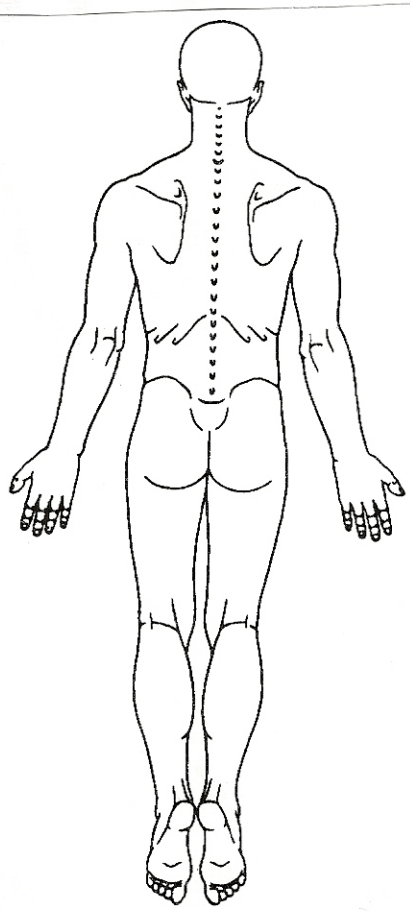
Note: A letter of protection is required if you are represented by an attorney.

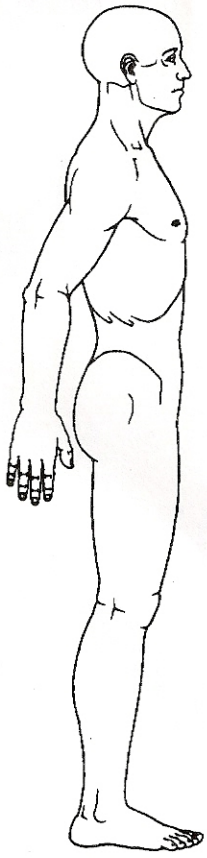
I.,_____, certify that the information provided on this intake is accurate, and that I will inform Ian A. Cyrus, MS, R.Ac. if there are any changes to this information.

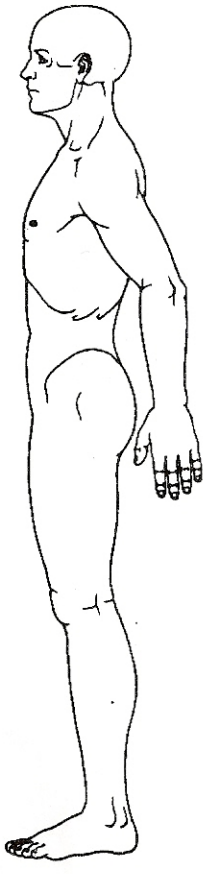
-See next page-

On the following drawings, please shade in areas which you feel should be addressed









Ian A. Cyrus, L.Ac.

Acupuncture and Oriental Medicine

Late Visit, Late Cancellation , and No show Policy Advisory

1. Please be on time for your visits. Initial visits are one (1) hour and follow-ups are 30 – 40 minutes in duration. In the event you are late, you will only be afforded the time remaining. You will be billed the cost of that visit.

2. Twenty-four hours advance notice is required for all cancellations, and rescheduling of appointments in order to avoid billing. In the event this requirement is not honored, you will be billed the cost of that visit.

3. No shows will be billed the cost of that visit.

Signature:_____ Date:_____

This is to certify that I have read and understood this advisory