East-West Healing Arts Acupuncture Intake Form

Name: _____ **Age:** ___ **Sex:** __ **Occupation:** _____

Date of Ist Visit: _____ **Wt:** ____ **B/P:** _____

Chief Complaint: _____ **Onset:** _____

History of Present Illness

How did the condition begin? _____
Describe the symptoms: _____
_____
Is it continuous, sporadic or episodic in nature? _____
Is it worse in the am, aftn or pm? _____
What aggravates it? _____
What makes it better? _____
To what extent if any does it interfere with your daily activities (work, sleep, exercise, sex etc.? _____
_____
Have you consulted a physician regarding this problem and if so what was the diagnosis/treatment plan?
_____
_____
_____

If so name the physician you consulted and his/her specialty? _____

Family Medical History (indicate family relation)

Cancer _____ **Diabetes** _____ **Heart Disease** _____
High/Low BP _____ **Stroke** _____ **Thyroid Disease** _____
Seizures _____ **Allergies** _____ **Alcoholism** _____
HIV/AIDS, STD _____ **Hepatitis** _____ **Other:** _____
Parents' age/health: _____
Siblings' age /health: _____
Children's age/health: _____

Past Medical History (include date)

Cancer _____ **Diabetes** _____ **Heart Disease** _____
High/Low BP _____ **Stroke** _____ **Thyroid Disease** _____
Seizures _____ **Allergies** _____ **Alcoholism** _____
HIV/AIDS, STD _____ **Hepatitis** _____ **Other:** _____
_____
Childhood Illnesses: _____
Surgeries: _____
_____
Major Traumas (auto accidents, falls, etc.): _____

Birth History: (prolonged labor, forceps delivery, C-section, etc.): _____

Allergies (airborne, contact, food, perennial or seasonal): _____

Current Medications (List dosage and freq): _____

Herbs, vitamins, minerals, etc (dosage and freq): _____

Temperament Tendency: Quick Tempered Depressed Moody Overly Cheerful Anxious Sad Fearful Other: _____

Psychosocial (family, romantic, friend and work relationships): _____

Occupational Stresses (chemical, physical, psychological, etc.): _____

Exercise (List type, dur and freq): _____

Habits (List qd consumption/and # yrs where indicated): Smoking: ___# pks ___# yrs age ____to_____
Alcohol:# oz/qd wk _____Coffee _____Tea _____Recreational Drugs (name & type) _____

Other: _____

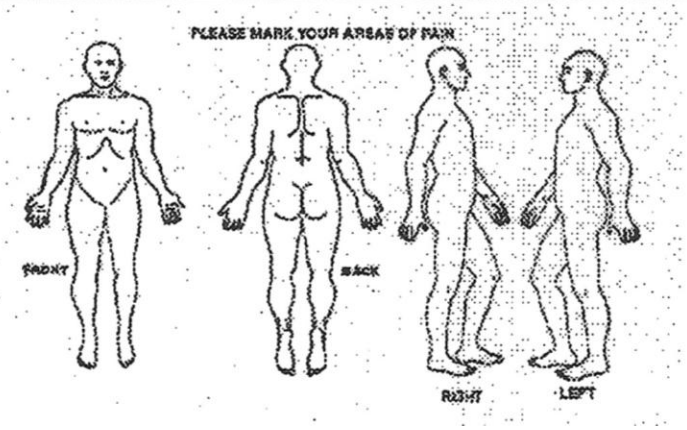
Physical Examination

Appearance: Discolored Edema Atrophy Comment: _____

Palpation: Tender Sensitive Lump Lesion Comment: _____

ROM: C Spine L Spine Shoulder Jt Elbow Wrist Fingers Hip Jt Knee Ankle Toes
Comment: _____

Other Findings (Reflexes, Tests, etc): _____



TCM 4 Diagnostic Methods
Inquiring

Appetite: Excess Poor Craving **Comment:** _____
Diet: Vegetable Red Meat Poultry Seafood. **Describe Daily Meals:** _____
_____
_____
Taste: Bitter Sweet Greasy **Comment:** _____
Stool: Diarrhea Constipated Loose Dry **Comment:** _____
Drinking: Excess Little Cold Hot **Comment:** _____
Urine: Frequent Scanty Painful Difficult **Comment:** _____
Sleep: Poor Heavy Restless Dream Disturbed **Comment:** _____
_____
Thermofeeling: Feverish Chilly (Extr or Trunk) Hot flashes **Comment:** _____
Perspiration: Frequent Absent Profuse Night Sweats **Comment:** _____
Favorite Season: Spring Summer Late Summer Autumn Winter. _____
Favorite Color: Green Red Yellow White Black Blue **Comment:** _____
Head: Dizzy Drowsy Headache **Comment:** _____
Eyes: Blurry vision Dry Watery **Comment:** _____
Ears: Ringing Poor hearing Pain Discharge **Comment:** _____
Nose: Dry Discharge Bleeding **Comment:** _____
Throat: Sore Dry Dysphagia **Comment:** _____
Other: SOB: inspir/expir Chest palpitations Poor memory: short/long term Poor concentration.
Comment: _____
Pain Location: Hd Nk Sh Chest Abd: Up Lo Back: Up Mid Lo UE LE Jts (All; Sh R L; Elbow R,L; Wrist R,L; Hand R,L; Hip R,L; Knees R,L; Ankle R,L; Feet R,L). _____
Comment: _____
Describe Pain: <u>Onset:</u> Sudden Gradual <u>Intensity:</u> 0-10 Scale:____ <u>Nature:</u> Sharp/Stabbing Dull Achy Spasmodic Burning Distending Hollow Pins/Needles <u>Loc:</u> Fixed Moveable: <u>Dur:</u> #m's_____ <u>Freq:</u> Constant Intermittent Episodic <u>Time of day</u>: AM AFTN PM **Comment:** _____
_____

OB/GYN:

Age at:	**Menarche:** ____	**Menopause:** ____	**Comment:** _____
Cycle:	**Shortened**	**Prolonged**	**Comment:** _____
Amt:	**Excess**	**Heavy Light**	**Comment:** _____
Color:	**Light**	**Dark Bright**	**Comment:** _____
Quality:	**Thin**	**Thick Clots**	**Comment:** _____
Cramps:	**Pre-menstr**	**During**	**Comment:** _____
PMS:	**Yes**	**No**	**List sx:** _____
Leukorrhea:	**Thick**	**Watery Profuse Yellowish Odor**	**Comments:** _____

 # Pregnancies: ___ **# Miscarriages:** ___ **#Abortions:** ___ **Sexually Active:** ___ **BCP Method:** _____
Comment: _____

Looking

Vitality (Eyes): Dispirited Hyperactive Depressed **Comment:** _____
Appearance (Build): Slim Overweight Medium **Comment:** _____
Color (Complexion): Pale Reddish Yellow **Comment:** _____

Listening /Smelling

Respiration: Feeble Heavy Shallow **Comment:** _____

Speech: Feeble Loud Low **Comment:** _____

Cough: Feeble Coarse Dry **Sputum (Color & Viscosity)** **Comment:** _____

Odor (Discharges) Comment: _____

Palpation

Acupoints, Body:

Finding: Lump Lesion Likes pressure Dislikes pressure Prefers cold Prefers heat _____

Comment: _____

Tongue and Pulse Diagnosis

Tongue: _____

_____

Pulse: _____

_____

Assessment

Impression: _____

TCM: _____

_____

Treatment Plan

Tx Principle: _____

_____

Acupoints: _____

_____

Other Modalities: Auricular Acup Scalp Acup EMS Moxibustion Cupping Cutaneous Needling Warm Needling **Comment:** _____

_____

Tx Plan: _____

_____

Recommendations: _____

_____

_____

_____

Acupuncturist's Signature: _____ **Date:** _____

Carole A Berberich L. Ac.