Acupuncture Plus Holistic Center
3383 Mariner Blvd
Spring Hill FL 34609
(352) 683 – 9499
(352) 666-2857 fax

Patient Intake Form

Today's Date_____

Name | Birthdate | Age | Ht. | Wt.

Address | Marital Status □ M □ S | Gender □ M □ F

City, State, Zip

Home Phone | Mobile | Work

E-Mail Address

Occupation

Emergency Contact: Name & Phone

Reason for visit today | Have ever had acupuncture? □ Yes □ No | Chinese herbal medicine? □ Yes □ No

How long have you had this condition?

Is it getting worse? | Does it bother your: □ Sleep □ Work □ Other (what?)

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

Are you under the care of a physician now? □ Yes □ No | If yes, for what?

Who is your physician? | Physician's Phone

Other concurrent therapies

Health Insurance
Insurance Co. Name | Policy#
Address | Phone
City, State, Zip

Medicare
Insurance Co. Name | Policy#
Address | Phone
City, State, Zip

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Family Medical History

□ Allergies	□ Arteriosclerosis	□ Cancer	□ Diabetes	□ Seizures
_____	□ Asthma	_____	□ Heart Disease	□ Stroke
_____	□ Alcoholism	_____	□ High Blood Pressure	

Your Past Medical History

□ AIDs/HIV	□ Emphysema	□ Pacemaker	□ Thyroid Disorders	□ Whooping Cough
□ Alcoholism	□ Epilepsy	□ Pleurisy	□ Major Trauma	□ Other (Specify & list)
□ Allergies	□ Goiter	□ Pneumonia	(Car, Fall, etc.-list)	
□ Appendicitis	□ Gout	□ Polio		
□ Arteriosclerosis	□ Heart Disease	□ Rheumatic Fever		
□ Asthma	□ Hepatitis	□ Scarlet Fever		
□ Birth Trauma (your own)	□ Herpes □ High Blood Pressure	□ Seizures □ Stroke	□ Tuberculosis □ Typhoid Fever	
□ Cancer	□ Measles	□ Surgery (list)	□ Ulcers	
□ Chicken Pox	□ Multiple Sclerosis		□ Venereal Disease	
□ Diabetes	□ Mumps			

Your Lifestyle

□ Alcohol	□ Drugs	**Regular Exercise**	
□ Tobacco	□ Stress	Type	Frequency
□ Marijuana	□ Occupational Hazards	Type	Frequency

General Symptoms

□ Poor Appetite	□ Poor sleep	□ Bodily heaviness	□ Chills
□ Heavy appetite	□ Heavy sleep	□ Cold hands or feet	□ Night sweats
□ Strongly like cold drinks	□ Dream-disturbed sleep	□ Poor circulation	□ Sweat easily
□ Strongly like hot drinks	□ Fatigue	□ Shortness of breath	□ Muscle cramps
□ Recent weight loss/gain	□ Lack of strength	□ Fever	□ Vertigo or dizziness
□ Bleed or bruise easily	□ Peculiar taste (describe)		

Head, Eyes, Ears, Nose,Throat

□ Glasses	□ Night blindness	□ Sores on lips or tongue	□ Swollen glands	□ Migraines
□ Eye Strain	□ Glaucoma	□ Dry Mouth	□ Lumps in Throat	□ Concussions
□ Eye pain	□ Cataracts	□ Excessive saliva	□ Enlarged thyroid	Other head or neck problems
□ Red eyes	□ Teeth problems	□ Sinus problems	□ Nose bleeds	
□ Itchy eyes	□ Grinding teeth	□ Excessive phlegm	□ Ringing in ears	
□ Spots in eyes	□ TMJ	□ Color of phlegm	□ Poor hearing	
□ Poor vision	□ Facial pain		□ Earaches	
□ Blurred vision	□ Gum problems	□ Recurrent sore throat	□ Headaches	

Respiratory

□ Difficulty breathing when lying down	□ Asthma/wheezing		Thick or thin?	□ Coughing blood
□ Shortness of breath	□ Cough		Color of phlegm	□ Pneumonia
□ Tight chest	wet or dry?			

Cardiovascular

□ High blood pressure	□ Low blood pressure	□ Chest pain	□ Tachycardia	□ Phlebitis
□ Blood clots	□ Fainting	□ Difficulty breathing	□ Heart palpitations	□ Irregular heartbeat

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Gastrointestinal

□ Nausea	□ Diarrhea	□ Itchy anus	Bowel movements:
□ Vomiting	□ Constipation	□ Burning anus	Frequency
□ Acid regurgitation	□ Laxative use	□ Rectal pain	Color
□ Gas	□ Black stools	□ Hemorrhoid	Texture/form
□ Hiccup	□ Bloody stools	□ Anal fissures	Odor
□ Bloating	□ Mucous in stools		
□ Bad breath	□ Intestinal pain or cramping		

Musculoskeletal

□ Neck/shoulder pain	□ Upper back pain	□ Joint pain	□ Limited range of motion	Other (describe)
□ Muscle pain	□ Low back pain	□ Rib pain	□ Limited use	

Skin and Hair

□ Rashes	□ Eczema	□ Dandruff	□ Change in hair/skin texture	Other hair or skin problems
□ Hives	□ Psoriasis	□ Itching	□ Fungal infections	
□ Ulcerations	□ Acne	□ Hair loss		

Neuropsychological

□ Seizures	□ Poor memory	□ Irritability	□ Considered/attempted suicide	Other (specify)
□ Numbness	□ Depression	□ Easily stressed	□ Seeing a therapist	
□ Tics	□ Anxiety	□ Abuse survivor		

Genito-urinary

□ Pain on urination	□ Blood in urine	□ Venereal disease	□ Increased libido	□ Impotence
□ Frequent urination	□ Unable to hold urine	□ Bedwetting	□ Decreased libido	□ Premature ejaculation
□ Urgent urination	□ Incomplete urination	□ Wake to urinate	□ Kidney stone	□ Nocturnal emission

Gynecology

□ Age menses began	□ Duration of flow	□ Vaginal discharge	# Pregnancies	Age at Menopause
		(color)		
Length of cycle	□ Irregular periods	□ Vaginal sores	# Live Births	Date of last PAP
(day 1 to day 1)	□ Painful periods	□ Vaginal odor		
	□ PMS	□ Clots	Premature births	Date last period began
		□ Breast lumps		

Other

_____

_____

_____