Patient Intake Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full Name	Sex ☐ F ☐ M	Date	
Date of Birth	Age	Occupation	
Main phone #	Other phone #		
E-mail address	Allow email contact by Dr. Sparks ☐ Yes ☐ No		
Emergency contact name & phone	Marital status	# of children	
Address: Street	City	State	Zip
Family physician	Chiropractor		
Do you have health insurance? ☐ Yes ☐ No	If yes, name of insurance company		
Does your insurance cover acupuncture? ☐ Yes ☐ No ☐ ?	Have you ever been treated by acupuncture before?		

Main problem(s) :
____

What diagnosis, if any, have you received for this problem?
____

When did this problem begin?
____

What are the causes of this problem?
____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?
____

What kind of treatment have you tried?

How did you find out about our clinic? ☐ *Friends/Relatives (name)*________________________
☐ *Direct mail* ☐ *Location or walk in* ☐ *Website* ☐ *Referred by*________________________
☐ *Yellow pages* ☐ *Periodicals* ☐ *Other (please specify)*

____

What makes this problem worse?
____

What makes this problem better?
____

Is there anyone in your family with the same/similar problems?____________

Remarks and additional information:

____

____

____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Surgeries:_________________________________ **Hospitalization**:________________________

Significant trauma:(auto accidents, sports injuries, etc)

____

Allergies: (drugs, chemicals, foods, environmental)

____

Medicines taken within the last two months (including Vitamins, OTC drugs, herbs, etc., and their dosages)

____

Occupation ___________________________ Do you usually work: ☐ indoors ☐ outdoors ?

Occupational stress (chemical, physical, psychological, etc)

____

Personal Height__________ Weight now____________ One year ago ________________

Weight maximum ___________ @Year ____________

Habits Do you smoke? ☐ Yes ☐ No What? _____________ How many per day?_______
Since when? _________

Please describe any use of drugs for non-medical purposes:

____

Do you exercise regularly? ☐ Yes ☐ No Please describe your exercise program:

____

How many hours do you sleep in general?___________
What time do you usually go to bed?__________

Diet How much coffee do you drink? _____cups/day Colas ______number/day
Tea _____cups/day

What kind of alcoholic beverages do you usually drink, if any? ______________

Average number of alcoholic beverages/week, if any? __________

How much water do you drink per day? __________

Are you a vegetarian? ☐ Yes ☐ No ☐ Yes, but not so strict.

Do you eat a lot of spicy food? ☐ Yes ☐ No

Remarks and additional information (e.g. diet)

____

Please describe your average daily diet (Please be as specific as possible):

Morning

____

Afternoon

____

Evening

____

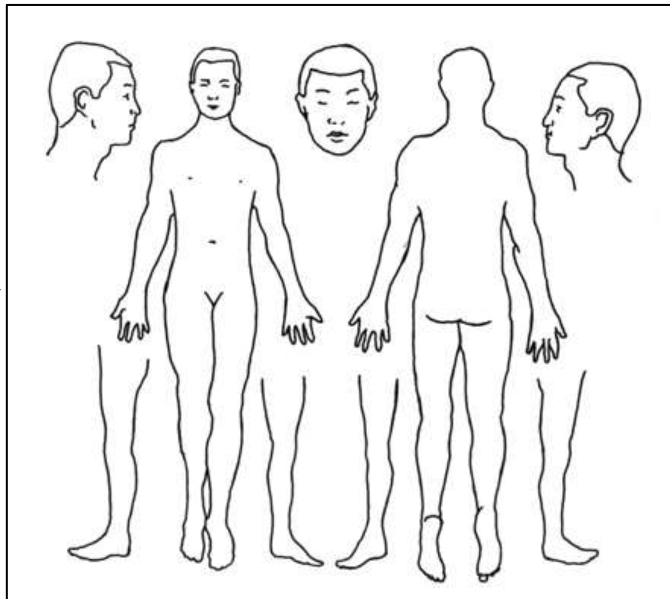
Snacks

____

Indicate painful or distressed areas:

Mark the "following" where you feel pain:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

☐ Poor appetite ☐ Poor Sleep ☐ Fatigue ☐ Fevers ☐ Chills
☐ Night sweats ☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Change in appetite
☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain
☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot drinks)

Sudden energy drop (What time of day) _________ Favorite time of year ___________
Worst time of year _________

Skin & hair

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema
☐ Pimples ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair ☐ Purpura
☐ Change in hair or skin textures ☐ Other?

Musculoskeletal

☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in the muscles ☐ Tremors
☐ Cold hands/feet ☐ Difficulty walking ☐ Swelling of hands/feet ☐ Shoulder pain ☐ Back pain
☐ Hernia
☐ Numbness ☐ Tinglin ☐ Spinal curvature ☐ Neck tightness ☐ Neck pain ☐ Paralysis
☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Sprain of joint ☐ Other

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Head, eyes, ears, nose, and throat

☐ Glasses/lens ☐ Concussions ☐ Dizziness ☐ Migraines

☐ Eye strain ☐ Night blindness ☐ Color Blindness ☐ Poor vision ☐ Eye pain ☐ Cataracts
☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes
☐ Sinus problems ☐ Nose bleeding ☐ Teeth problems ☐ Sore throat ☐ Grinding teeth

☐ Facial pain ☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other

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Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting
☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other

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Respiratory

☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty in breathing

☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm – What color? _________

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Gallbladder problems ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Rectal pain
☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Parasites ☐ Bad breath ☐ Chronic laxative use
Bowel movements: Frequency _______ Color ______ Odor ______ Texture/ Form _______________

Neuro-psychological

☐ Loss of balance ☐ Lack of coordination ☐ Concussion
☐ Depression ☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar

Genito-urinary

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Kidney stone ☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection
☐ Pain in genital ☐ Itching of genital ☐ Other

Female

☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal/genital discharge

☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods

☐ Breast tenderness ☐ Breast Lumps ☐ Fertility Problems ☐ Hot flashes ☐ Moodiness related to periods

______ number of pregnancies ______ number of births ______ Miscarriages ______ Abortions

______ Premature births ______ Cesareans ______ Difficult delivery

First date of last period _______________ Age of first menses _____ Duration of periods ______days, cycle ____ days

Do you practice birth control? ☐ Yes ☐ No
If yes, what type and for how long ____________________

If you're on birth control pills, what are you taking and for how long?
____

Male

☐ Prostate problems ☐ Discharge ☐ Impotence ☐ Frequent seminal emission ☐ Fertility problems

☐ Ejaculation problems ☐ Painful/swollen testicles ☐ Other

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature:__________________________ ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Are there any other health issues you want to discuss with us?

Signature: **Date:**