Kymberlie Landgraf
MAOM, L.Ac.

PATIENT INTAKE FORM

Thank you for coming. Please take the time to fill out this questionnaire carefully in order to receive a complete evaluation. All of your information will be confidential. If you have any questions, please ask.

Full Name:	**Date:**
Home Phone:	**Alt. Phone:**
Street Address:	**City:**
State: **Zip:**	**E-mail Address:**
Occupation:	**S.S. #:**
Emergency Contact:	**Marital Status (Circle): S M D W # Children:**
Family Physician:	**Chiropractor:**
Health Insurance: ☐ **Y** ☐ **N**	**Name of Company:**
Do they cover acupuncture? ☐ **Y** ☐ **N** ☐ **Not Sure**	**Have you ever received acupuncture?** ☐ **Y** ☐ **N**
Date of Birth: / / **Age:**	**Sex:** ☐ **F** ☐ **M**
How did you hear about this clinic? ☐ *Walk in* ☐ *Yellow Pages* ☐ *Periodicals* ☐ *Website* ☐ *Referred By:* ☐ *Other:* Please initial here to give your permission for us to thank the person who referred you for treatment::	

Main Problem(s): You would like help with _____.

When did this problem begin? What are the precipitating factors?

Have you been given a diagnosis for this problem? If so, what was it?

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

What kind of treatment have you tried?

What makes this problem worse? What makes this problem better?

Is there anybody in your family with the same/similar problems? Remarks and additional information:

Medical History: (Please include the month/year when diagnosis was established)

Significant illness: Cancer Diabetes Hepatitis Thyroid Disease Seizures
Fibromialgia Arthritis Tuberculosis Hypertension Emotional Imbalance Anemia
Breathing Problems Heart Disease Digestive Disorders HIV/AIDS Positive Venereal Disease
Other (please specify):

Surgeries: **Hospitalization:**

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

Allergies: (drugs, chemicals, foods)

Family Medical History (Please specify member) Cancer Diabetes Hepatitis
Hypertension Heart Disease Stroke Asthma Alcoholism Miscarriage Other (please specify)

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: _____ Current Weight: _____ One year ago: _____

Weight Maximum: _____ @ year _____.

Habits Do you smoke? ☐ Y ☐ N What? _____ How many per day? _____ Since when? _____

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

Do you exercise regularly? ☐ Y ☐ N Please describe your exercise program:

How many hours do you sleep in general? _____ What time to you go to bed? _____

Diet How much coffee do you drink? _____ cups/day ; Colas _____per day ; tea _____ cups/day

What kind of alcoholic beverages do you usually drink? _____ Average # drinks per week? _____

How much water do you drink per day? _____

Are you a vegetarian? ☐ Y ☐ N ☐ Yes, but not so strict Do you eat a lot of spicy food? ☐ Y ☐ N

Remarks and additional information (e.g. diet)

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

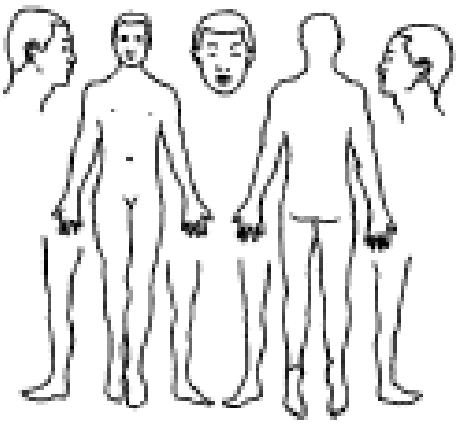
Morning:

Afternoon:

Evening:

Snacks:

Indicate painful or distressed areas:



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

General ☐ Poor Appetite ☐ Poor Sleeping ☐ 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 ☐ Dry/brittle nails ☐ Acne/rosacea ☐ Psoriasis ☐ Other?

Musculo-skeletal ☐ Joint Disorders ☐ Muscle Weakness ☐ Muscle stiffness ☐ Tremors ☐ Pain/soreness in muscles
☐ Difficult Walking ☐ Cold Hands/Feet ☐ Swelling of hands/feet ☐ Sweaty palms/feet ☐ Back Pain ☐ Spinal curvature
☐ Neck tightness ☐ Hernia ☐ Numbness ☐ Tingling ☐ Paralysis ☐ Knee pain
☐ Hip pain ☐ Neck pain ☐ Sciatica ☐ Arthritis ☐ Other

Head, eyes, ears, nose and throat ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens
☐ Eye strain ☐ Eye pain ☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts
☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Sinus problems ☐ Nose bleeds
☐ Sore throat ☐ Grinding teeth ☐ Spots in front of eyes ☐ Facial pain ☐ Jaw clicks ☐ Sores on lips/tongue
☐ Gum problems ☐ Difficulty swallowing ☐ Other

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

Respiratory ☐ Cough ☐ Coughing blood ☐ Congestion ☐ Wheezing ☐ Difficulty in breathing
☐ Bronchitis infection ☐ Pneumonia ☐ Shortness of breath ☐ Chest pain ☐ Bad breath ☐ Repeated sinus
☐ Indigestion ☐ Shallow breathing
☐ Production of phlegm or nasal discharge ☐ Clear ☐ White ☐ Yellow ☐ Green ☐ Bloody ☐ Thick ☐ Thin & watery

---

Gastrointestinal ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Black stools ☐ Blood in stools ☐ Dry stool ☐ Incomplete BM ☐ Infrequent bowel movements
☐ Hemorrhoids ☐ Parasites ☐ Gallbladder problems ☐ Dry mouth/throat ☐ Frequently thirsty ☐ Lack of thirst
☐ Rectal pain ☐ Abdominal pain/cramps ☐ Indigestion ☐ Acid reflux ☐ Chronic laxative use
☐ Bad breath

Bowel movements: Frequency _____ **Color:**_____ **Odor** _____ **Texture/Form** _____

Neuro-psychological ☐ Depression ☐ Fearful ☐ Worry easily ☐ Easily stressed ☐ Panic attacks
☐ Suicidal feelings ☐ Loss of balance ☐ Concussion ☐ Anxiety ☐ Stress ☐ Bad temper
☐ Bi-polar ☐ Restlessness ☐ Lack of coordination ☐ Tendency to become obsessive in your work or relationships

---

Genito-urinary ☐ Pain on urination ☐ Blood in urine ☐ Frequent urination ☐ Urgency to urinate ☐ Unable to hold urine
☐ Nighttime urination ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection
☐ Pain in genitals ☐ Itching of genitals ☐ Kidney stones ☐ Low sexual desire ☐ Excessive sexual desire
☐ Urination issues: ☐ Frequent ☐ Urgent ☐ Profuse ☐ Scanty ☐ Painful
☐ Burning ☐ Bloody ☐ Other

Temperature: ☐ Aversion to cold ☐ Easily chilled ☐ Cannot regulate temperature ☐ Cold hands
☐ Aversion to heat ☐ Easily overheated ☐ Low grade afternoon fever ☐ Cold feet ☐ Night sweats ☐ Hot flashes
☐ Sweats easily/spontaneously sweats

Female ☐ Fibroids ☐ Frequent vaginal infections ☐ Irregular periods ☐ Endometriosis ☐ Pelvic infection
☐ Ovarian cysts ☐ Clots ☐ Vaginal/genital discharge ☐ Pain/cramps prior/during periods

Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions _____
Premature births _____ Caesareans _____ Difficult deliveries _____
First day 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 are using birth control pills, what are you taking and for how long? _____

Male
☐ Prostate problems ☐ Discharge ☐ Impotence ☐ Frequent seminal emission
☐ Fertility problems ☐ Painful/swollen testicles ☐ Ejaculation problems ☐ Other

---

Please rate your current pain or discomfort level: (very slight) 1 2 3 4 5 6 7 8 9 10
Please explain how these conditions affect or impair your daily activities. Examples may include your overall quality of life, work/career, family life, hobbies, self-esteem, etc.

Do you have any history of emotional trauma?
Do you have any history of surgeries or hospitalizations?
Do you have any allergies to food, drugs, environment, etc?
Do you use artificial sweeteners:

FOR YOUR INFORMATION – PLEASE READ CAREFULLY AND SIGN

1. Only sterile, disposable needles are used for your treatment.
2. Occasionally you may get a small hematoma (a little bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern – it will go away after a few days. Gentle pressure applied to the site will stop any small amount of bleeding that is occurring under the skin.
3. Any herbal prescription is intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.
4. After receiving acupuncture treatment, you may feel a little light-headed. If so, please have a seat in our waiting room until this passes.

I have read and understand all of the above information and guarantee this form was completed correctly and 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:**

Identification information update: **Date:**

Name: **Occupation:** **Marital Status:**

Email Address: **Phone:**

Address:

Insurance Company:

Other:

Identification information update: **Date:**

Name: **Occupation:** **Marital Status:**

Email Address: **Phone:**

Address:

Insurance Company:

Other:

Identification information update: **Date:**

Name: **Occupation:** **Marital Status:**

Email Address: **Phone:**

Address:

Insurance Company:

Other:

Note: