Four Seasons Acupuncture, Inc.
Patient Intake Form

Patient Name: _____ Date: _____

Reason For Visit: _____

_____

Are Your Under Physician Care: Y / N If Yes, Physician Name & Phone: _____

Please List Current Medications/Supplements: _____

_____

_____

Allergies (List): _____

Surgeries/Traumatic Injuries: _____

_____

Family Medical History

☐ Allergies	☐ Depression	☐ High Blood Pressure	☐ Asthma	☐ Stroke
☐ Arthritis	☐ Heart Disease	☐ Respiratory Disease	☐ Alcoholism	☐ Diabetes
☐ Cancer	☐ Seizure			

Habits / Excessive Use

☐ Alcohol	☐ Coffee	☐ Food	☐ Tea	☐ Exercise
☐ Artificial Sweetener	☐ Cola	☐ Salt	☐ Other	☐ Sugar
☐ Chocolate	☐ Drugs	☐ Sex	☐ Cigarettes	

General (please check all that apply in last 3 months)

☐ Poor Appetite	☐ Fevers	☐ Desire Cold Drinks	☐ Low Energy	☐ Vertigo
☐ Change In Appetite	☐ Chills	☐ Insomnia	☐ Body Heaviness	☐ Dizzy
☐ Large Appetite	☐ Sweating	☐ Easy To Fall Asleep	☐ Sleep Apnea	☐ Bleed or Bruise Easy
☐ Cravings	☐ Night Sweats	☐ Difficult To Fall Asleep	☐ Dream Disturbed Sleep	☐ Headache
☐ Weight Gain	☐ Sweat Easily	☐ Desire Hot Drinks	☐ Fatigue	☐ Hot Flash
☐ Back Pain	☐ Joint Pain	☐ Neck Pain	☐ Shoulder Pain	☐ Irrititability
☐ Weight Loss	☐ Nausea/Vomitting	☐ Gas/Belching	☐ Diarrhea/Constipation	

Your Past Medical History

☐ AIDs/HIV	☐ Candia	☐ Herpes	☐ Pneumonia	☐ Stroke
☐ Alcoholism	☐ CFS	☐ Hernia	☐ Prostate Problems	☐ Substance Abuse
☐ Allergies	☐ Colitis	☐ Herniated Disc	☐ Osteoporosis	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatoid Arthritis	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ High Cholesterol	☐ STD	☐ Ulcers
☐ Auto Immune Disease	☐ Gout	☐ Kidney Disease	☐ Mononucleosis	☐ Whooping Cough
☐ Bleeding Disorder	☐ Gall Stones	☐ Liver Disease	☐ Low Blood Pressure	☐ Migraines
☐ Breast Cysts	☐ Headaches	☐ Heart Disease	☐ MS	☐ Hepatitis
☐ Acid Regurgitation	☐ Anxiety	☐ Depression	☐ Infertility	☐ Bladder Issues
☐ Impotency	☐ Irritable Bowel	☐ Decreased Libido	☐ Bi Polar	☐ Cancer

Gynecology

☐ Age Menses Began	☐ Endometriosis	☐ Spotting Between Periods	☐ Date of Last PAP _____	☐ # Pregnancies _____
☐ Length of Cycle	☐ Pelvic Pain	☐ Vaginal Discharge / Odor	☐ Date of Last Period _____	☐ # Live Births _____
☐ Duration of Flow	☐ Fibroids	☐ Flow Thick/Thin	☐ Color _____	☐ # Miscarriages _____
☐ Irregular Period	☐ Infertility	☐ Amount Scanty / Heavy	☐ Clots	☐ # Premature Births _____
☐ Painful Period	☐ Ovarian Cysts	☐ PMS	☐ Decreased Libido	☐ # Abortions _____

Other

☐ _____