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Numinous Health

**Confidential Intake Form**

**Date:**

**\*Please note: Any information provided on these forms are kept strictly confidential.**

**Patient Information**

Name: Gender:

Age: Date of Birth:

Home Address:

Home Phone: Cell: Work Phone:

Email:

Emergency Contact: Relationship to Patient:

Emergency Contact Phone number:

Primary Care Physician (PCP): PCP Phone:

Date of last medical examination:

Occupation:

* **Experience**

Have you received acupuncture treatment before? YES NO

If yes, for what conditions and what was the outcome?

* **Complaint**

What would you like treated by Acupuncture?

How and when did this condition develop?

Was the onset: SUDDEN GRADUAL

Symptoms are worsened by:

Symptoms are better by:

Medical diagnosis received, if any:

What other treatments are you doing/have you done to manage your condition?

How does this condition affect your daily activities?

**On the diagram, please shade in the areas that you feel need to be addressed:**

    

* **Medications, Supplements and herbs**

Please list ALL medications, (prescriptions & OTC drugs) supplements and herbs you are taking, even if taking occasionally:

 ***Medications, supplements, or herbs: Indication/For treatment of:***

 1. 1.

 2. 2.

 3. 3.

 4. 4.

 5. 5.

 6. 6.

 7. 7.

 8. 8.

 9. 9.

 10. 10.

* + List any allergies**:**

* **Personal Medical History**

**Birth:** Describe anything significant/traumatic about your birth:

**Vaccination History:** Any unusual reaction? Any unusual vaccination?

**Childhood Illnesses (0-12 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

**Age:**

**Age:**

**Adolescence Illnesses (13-17 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

**Age:**

**Age:**

**Adulthood Illnesses (18 – 35 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

**Age:**

**Age:**

**Adulthood Illnesses (36 & up):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

**Age:**

**Age:**

* **Family Medical History**

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

 **Mother**

 **Father**

 **Siblings**

 **Maternal Grandparents**

 **Paternal Grandparents**

* **Symptom Overview BY System**

**Please CIRCLE all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. UNDERLINE symptoms that have affected you BEFORE, but within the last year.**

**Musculoskeletal**

Joint clicking Limitation of movement Stiffness

Spasms or cramps Swelling Weakness

**Pain:**

Full body Facial (e.g. jaw) Neck Upper Back

Mid Back Low Back Shoulder Elbow Wrist

Hand Hip Knee Ankle Foot

OTHER (Please list)

 **Pain is:**

Sharp Achey Numb Deep Burning Dull

 Superficial Tingling

 Better: Heat Cold Movement AM PM

 Worse: Heat Cold Movement AM PM

**Eyes, Ears, Nose, Throat, Respiratory**

Loss of vision Eye pain Tearing or eye dryness

Eye discharge Eye redness Floaters (seeing spots)

Ear discharge Ear itchng Ear pain &/or infections

Loss of hearing Ringing/buzzing in ears

Problems w/ balance (vertigo)

Olfaction (sense of smell) impaired

Nose obstruction (stuffiness) Nose bleeds

Sinus pain, pressure &/or infections Frequent colds

Smoke? Yes No per day, for years

Chest pain &/or tightness Bluish discoloration of skin

Cough Coughing up blood (hemoptysis)

Shortness of breath (dypsnea) Sore throat

Sputum production Voice changes Wheezing

Phlegm/mucus Color?

OTHER (Please list)

**Cardiovascular**

Blood pressure /

Changes in skin temperature & color

Chest pain &/or pressure Edema Fainting (syncope)

Fatigue Palpitations Skin ulceration

Swelling of the ankles &/or legs

OTHER (Please list)

**Digestive**

Abdominal distention/bloating Abdominal mass

Abdominal pain Acid regurgitation &/or Heartburn

Alternating constipation/diarrhea Rectal bleeding

Constipation Diarrhea Gas Eating disorder

Indigestion Jaundice (yellow tint to skin &/or eyes)

Nausea Vomiting

OTHER (Please list)

Bowel movements: times a day/week

 Painful? Yes No

 Irregular Burning Undigested food in stool

 Loose stool Hard stool “Rabbit” stool

 Blood in stool Itchiness

 **Urogenital**

Difficulty with urine flow Incontinence

Painful urination (dysurea) Rashes Red urine

Urinary tract infection (UTI)

How often? Times

Color: Clear Pale yellow Dark yellow/orange

OTHER (Please list)

**Neurological**

Changes in consciousness Confusion Dizziness

Difficulty concentrating Paralysis Post shingles pain

Dysphasia (impaired ability to speak) Gait disturbance

Numbness and/or tingling Loss of consciousness

Problems coordinating movements Severe forgetfulness

Tremor Visual disturbance Weakness

OTHER (Please list)

**Integumentary (Skin)**

Changes in hair Changes in nails Unusual sweating

 Changes in skin color Itching (prurites) Never sweat

Rash and/or skin lesion Wounds that will NOT heal

Night sweats

 OTHER (Please list)

 **Psychological**

Feelings of grief Feelings of sadness Feeling manic

Feeling fearful/anxious/nervous Feeling irritable

Difficulty managing anger Extreme lack of emotion

Feeling worried or overly pensive Panic attacks

Feeling overwhelmed Extreme mood swings

Poor memory Difficulty concentrating

OTHER (Please list)

Are you: Married/Stable relationship Single

How do you feel about your relationship?

How do you hold stress?

If you hold stress in your body, where?

How do you feel about your work?

How do you relax?

**Sleep**

Difficulty falling asleep Dream disturbed sleep

Wake up & cannot fall back asleep

At what time(s) do you wake up & cannot fall back to

sleep?

How many hours do you sleep?

OTHER (Please list)

**WOMEN**

Abnormal vaginal bleeding Changes in hair distribution

Fertility concerns Irregular menstruation

Menopausal symptoms No menses

Pain with menses (dysmenorrhea) Unusual discharge

Pain during or after sexual relations Pelvic pain

Premenstrual (PMS) symptoms Sexual dysfunction

What type of birth control do you use?

How is your libido? High Low Normal

OTHER (Please list)

* **Are you currently pregnant? YES NO**
* **Are you presently trying to get pregnant? YES NO**

**Have you ever been pregnant?** YES NO If yes, how many pregnancies:

 # Births

 # Miscarriages

 # Abortions

**MEN**

Fertility concerns Prostate problems

Sexual dysfunction Unusual discharge

How is your libido? High Low Normal

OTHER (Please list)

* **MEDICAL DISEASES/CONDITIONS**

 **Please CIRCLE current conditions and UNDERLINE past/resolved conditions.**

AIDS/HIV Alcoholism &/or substance addiction

Allergies (If yes, pls indicate diagnosis & history)

Anemia Asthma Bell’s Palsy

Blood clotting disorder (If yes, pls indicate diagnosis & history)

Bipolar disorder

Cancer (If yes, pls indicate diagnosis & history)

Chron’s Disease &/or colitis Infertility

Chronic Fatigue Syndrome(CFIDS) Depression (Major)

Diabetes Eczema Endometriosis Fibroids

Lung disease(ex.COPD)(If yes, pls indicate diagnosis &history)

Fibromyalgia Gallstones

Heart disease (If yes, pls indicate diagnosis & history)

Hepatitis A / B / C Hernia Herpes

Hypertension Hypoglycemia

Irritable Bowel Syndrome (IBS)

Joint Replacement (If yes, pls indicate diagnosis & history)

Kidney Stones and/or Disease (If yes, pls indicate diagnosis & history)

Lupus Lyme Disease Lymph node removal

Mitral valve prolapse Mood Disorder Mononucleosis Multiple Sclerosis

Organ removal or transplant (If yes, pls indicate diagnosis & history)

Osteoarthritis Osteoporosis

Pacemaker (heart or stomach) Parkinson’s Disease

Pelvic Inflammatory Disease Polio Psoriasis

PTSD (Post-Traumatic Stress Disorder)

Reflux esophagistis (GERD) Rheumatic fever

Rheumatoid arthritis Scarlet Fever Schizophrenia

Scoliosis Seizures and /or epilepsy Shingles

Sleep Disorder Stroke Schizophrenia

Thyroid disease (If yes, pls indicate diagnosis & history)

Ulcer Trigeminal Neuralgia Tuberculosis

Vascular disease (e.g. phlebitis) (If yes, pls indicate diagnosis & history)

OTHER (pls list)

* **Lifestyle Information**
* **Diet & Nutrition**

How is your apetite? Good Poor No appetite Hungry all the time

Food cravings:

Food allergies/intolerances:

History of: Anorexia Bulimia Meals per day:

How often do you have: Meat day/week Vegetables day/week Dairy day/week

Caffeine (Coffee, Tea) day/week Sugar/Sweets day/week

Rate your preferences 1-5 (1=dislike most, 5=like most)

Salty Sweet Bitter Sour Spicy

Are you always thirsty? Yes No How do you prefer your drinks? Hot Cold

Alcohol consumption: drinks per: day/week

* **Exercise & Energy Level**

Do you exercise? Yes No

How often? times a week

What type of exercises do you do?

How is your energy? Low High Fluctuates

What time(s) of the day is your energy: High Low