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:

____

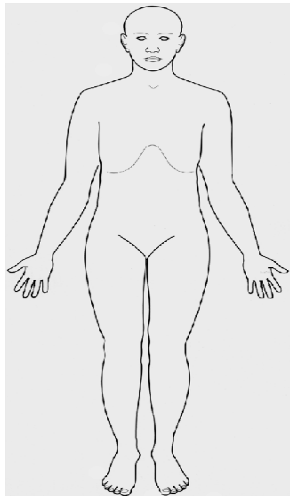
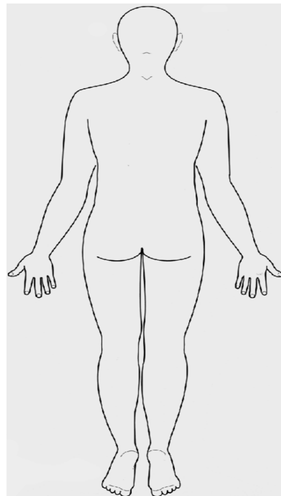
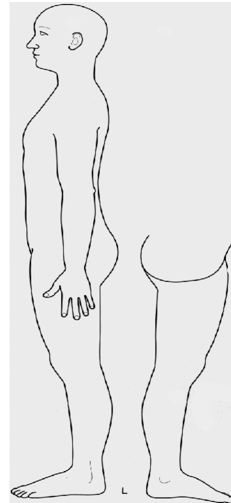
What other treatments are you doing/have you done to manage your condition?

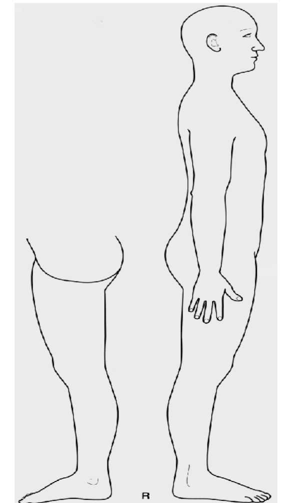
____

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 ________________