Debbie Young, AP (AP 2526) *(904) 501-1632*
Debbie@DebbieYoungAP.com **Date:**

Patient Intake

This is a **CONFIDENTIAL** questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **Height:** _____ **Weight:** _____

_____ **Occupation:** _____

Email: _____ **Marital Status:** _____ **# of Children**_____

Phone: (H) _____ **(W)** _____ **Have you ever been treated by acupuncture before?** ____

(C)_____ **Prefer contact #** _____ **When?**_____ **By Who?**_____

Physician: _____ **Chiropractor** _____

Do you have health insurance? □ **Yes** □ **No** **If yes, name of insurance company**_____

Does your insurance cover acupuncture? □ **Yes** □ **No** □ **How did you find out about our clinic?**_____

In Emergency, Notify: _____ **Relationship:** _____**Phone:** _____

Reason For Visit Today:_____

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? _____

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 check those that apply to yourself or family)

Condition	Self/Family		Condition	Self/Family		Condition	Self/Family		Condition	Self/Family	
Alcoholism			Depression			Gout			High Blood Pres.		
Allergies			Diabetes			Heart Disease			High Cholesterol		
Anemia			Drug Abuse			Hepatitis			Kidney Disease		
Arthritis			Emotional Dis.			HIV/AIDS			Pacemaker		
Asthma			Epilepsy						Stroke		
Cancer			GI Disorders						Thyroid Disease		

Surgeries: _____**Hospitalization:** _____

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

Allergies: (drugs, chemicals, foods, environmental):_____

Name:_____

Medications (please list current prescription, over-the-counter, and supplements you are taking)

Medication	Dosage	Date	Reason

Attach list if necessary
Are you interested in Herbal Perscriptions?_____

Lifestyle

Do you smoke? □ Yes □ No What? _____ How many per day? _____ Since when? _____

Do you drink alcohol?_____ If so, □ Beer □ Wine □ Liquor How many per day_____ week_____ month_____

Do you exercise regularly □ Yes □ No Please describe your exercise program: _____

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

How much of the following do you drink per day? Coffee _____ Tea _____ Soda _____ Water _____

Are you a vegetarian? □ Yes □ No □ Yegan Do you eat a lot of spicy food? □Yes □No

How would you describe your average diet?_____

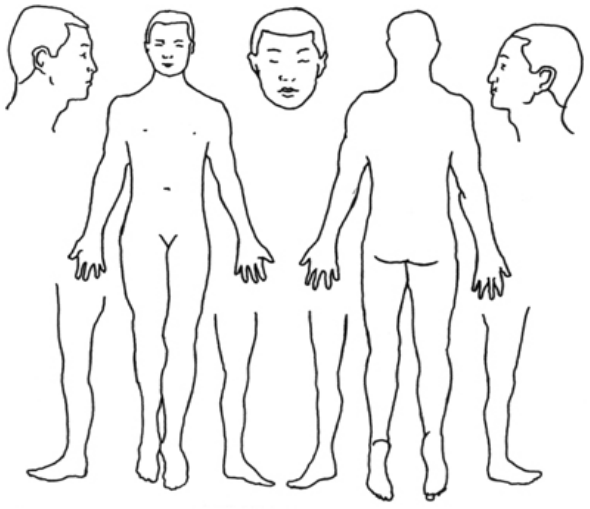
What do you want to change about your diet?_____

How would you rate your Stress level? low 1 2 3 4 5 6 7 8 9 10 high Source_____

Do you practice any stress reduction techniques?_____ Describe_____

How would you rate your general energy level? Low 1 2 3 4 5 6 7 8 9 10 high Best time of day_____

Pain: Please indicate areas of pain on the diagram below:



Severity: mild 1 2 3 4 5 6 7 8 9 10 10+

How would you describe the pain?
□ Dull/Aching □ Sharp/Stabbing □ Wandering
□ Fixed □ Burning □ Tingling □ Electrical
□ Numbness

What makes it better? □ Movement □ Rest
□ Heat □ Cold □ Pressure □ Nothing

What makes it worse? □ Movement □ Rest
□ Heat □ Cold □ Pressure

Name:_____

Symptom Checklist

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

General
☐ Poor appetite ☐ Poor sleep ☐ Fatigue ☐ Localized weakness
☐ Poor Balance ☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Change in appetite
☐ Night sweats ☐ Bleed or bruise easily ☐ Weight gain ☐ Weight loss ☐ Strong thirst (cold or hot drinks)
☐ Fevers ☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food
☐ Chills ☐ Sudden energy drop (What time of day) _____
Favorite time of year _____ Worst time of year _____

Skin & Hair
☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema
☐ Pimples ☐ Acne ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair
☐ Purpura ☐ Change in hair or skin texture ☐ Other?

Musculoskeletal
☐ Tremors ☐ Muscle weakness ☐ Pain/soreness in the muscles
☐ Joint disorders ☐ Cold hands/feet ☐ Difficulty walking ☐ Swelling of hands/feet
☐ Spinal curvature ☐ Back pain ☐ Hernia ☐ Numbness ☐ Tingling
☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain ☐ Hand/wrist pain
☐ Hip pain ☐ Knee pain ☐ Joint sprain,_____ ☐ Other?

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

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

Respiratory
☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing
☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm – What color? _____

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

Neuro-psychological
☐ Loss of balance ☐ Lack of coordination ☐ Paralysis ☐ Bi-polar
☐ Depression ☐ Anxiety ☐ Stress ☐ Bad temper ☐ Grief
☐ Suicidal Thoughts ☐ Fear ☐ Worry ☐ Obsessive/Compulsive

Genito-urinary
☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Kidney stones ☐ Incontinence ☐ Dribbling ☐ Pause of flow ☐ Frequent UTI
☐ Genital pain ☐ Genital itching ☐Genital rashes ☐ STD ☐ Other?

Male
☐ Prostate problems ☐ Discharge ☐ Erectile dysfunction ☐ Ejaculation problems
☐ Frequent urination ☐ Fertility problems ☐ Painful testicles ☐ Decreased libido ☐ Other

Name:_____

Female **Is there any possibility you are pregnant?** ☐ **Yes** ☐ **No**

☐ Pelvic infection ☐ Endometriosis ☐ Fibroids ☐ Ovarian cysts ☐ Hot flashes
☐ Irregular periods ☐ Amenorrhea ☐ Breast tenderness ☐ Breast Lumps/Cysts ☐ Painful Intercourse
☐ Moodiness related to periods ☐ Fertility Problems ☐ Frequent vaginal infections
☐ Pain/cramps prior/during periods ☐ Surgeries _____

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions
_____ Premature births _____ C-section _____ Difficult delivery

Menstruation

Age of first period _____ First date of last period _____ Date of last PAP_____Results_____

Duration of periods _____days, cycle _____ days. Flow: very light / light / moderate / heavy / very heavy
Color: ☐ Pale ☐ Bright red ☐ Dark red ☐ Brown ☐ Clots Lg / Sm ☐ Pain before / during / after

PMS: ☐ Breast soreness ☐ Bloating ☐ Moodiness ☐ Irritability ☐ Cramps Other_____

Perimenopausal: ☐ Skipped/irregular periods ☐ Hot flashes ☐ Moodiness ☐ Vaginal dryness
Menopause/age:_____ Hysterectomy/age and reason:_____

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_____

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

I have completed this form correctly to the best of my knowledge.

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