Preferred Health Solutions
Intake Form

Name:_____ Date of Birth: _____ Gender: _____
Address: _____City: _____State: _____ Zip: _____
Phone Numbers: (home) _____ (work) _____ (cell) _____
Emergency Contact:_____ Phone: _____
How did you hear about this clinic? _____

Consent to Treat:

I, the undersigned, understand acupuncture treatments to involve the use of needles, moxibustion, acupressure, tui na (Chinese massage), western massage, cupping, gua sha and/or electrical stimulation etc. The risks for acupuncture, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

Patient's Signature: _____ Dated: _____

Reason for today's visit: _____How Long?_____

☐ Yes, I have been treated by Acupuncture before, Date of last treatment ? _____

☐ Yes, I am currently under a physicians care for: _____
Name of Physician: _____ Phone:
_____

☐ Yes, I am currently taking prescription drugs.
Drugs currently taking? _____

_____

_____

☐ Yes, I have or have had an infectious disease. Describe: _____

- ☐ Yes, I have allergies.
- ☐ Foods – Describe: _____
- ☐ Medications – Describe: _____
- ☐ Bites/stings – Describe: _____
- ☐ Seasonal changes – Describe: _____
- ☐ Animals – Describe: _____

Family Medical History (please check if any of the following applies to any family members)

☐ AIDS	☐ Diabetes (I/II)	☐ Pulmonary Disease
☐ Alcoholism	☐ Heart disease	☐ Other
☐ Allergies	☐ Hypertension	☐ _____
☐ Asthma	☐ Seizures	☐ _____
☐ Cancer	☐ Stokes	

Describe:
Mother's Health Challenges:_____ Living/Deceased
Father's Health Challenges: _____Living/Deceased
Siblings' Health Challenges _____ Living/Deceased
# of Siblings _____Your Birth Order: ☐ oldest; ☐ middle; ☐ youngest; ☐ adopted
Grandparents Health Challenges: _____Living/Deceased

Personal Health History (please check if any of the following applies)

☐ Injuries? _____

☐ Accidents/Falls?_____

☐ Surgeries? List when and for what: _____

_____

_____

☐ AIDS
☐ Alcoholism
☐ Asthma
☐ Allergies
☐ Arteriosclerosis
☐ Birth Trauma (yours)
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Endocrine Disorder
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hypertension
☐ Multiple Sclerosis
☐ Thyroid Disease
☐ Childhood Fevers
☐ Childhood Illnesses
☐ Insomnia
☐ other_____
_____

Current Symptoms (please check if any of the following applies)

☐ headaches
☐ vision problems
☐ jaw/teeth pain
☐ ear pain
☐ sinus pain/problem
☐ breathing difficulties
☐ chest pain
☐ urination difficulties
☐ infertility
☐ impotence
☐ muscular pain
☐ joint dysfunction/ pain
☐ blood pressure – low/high
☐ indigestion
☐ constipation/ diarrhea
☐ skin disorders
☐ PMS
☐ Menstrual disorders
☐ Menopausal problems
☐ Anxiety
☐ Depression
☐ Overly emotional
☐ Insomnia

Life Style (please check where appropriate)

☐ Live alone
☐ Live with spouse/ significant other
☐ Roommate
☐ Live with parents
☐ Live with children
☐ Enjoy home
☐ Have family support
☐ Have financial support
☐ Religious
☐ Spiritual connection
☐ Work
☐ Work 9-5
☐ Work 2nd shift
☐ Work 3rd shift
☐ Work inconsistent hrs.
☐ Manage own business
☐ Enjoy work
☐ Retired/Unemployed
☐ Student full time
☐ Student part time
☐ Exercise seldom
☐ Exercise occasionally
☐ Exercise often
☐ Enjoy hobby

Personal Habits (please check where appropriate)

☐ currently use tobacco # per day? _____
☐ currently use alcohol #drinks per week? _____
☐ Recreational drugs
☐ former tobacco use # years quit? _____
☐ former alcohol use # years quit? _____

Supplements: (please list all that you are currently taking with dosage)

Herbs:

_____

_____

_____ Supplements:_____
_____ _____
_____

Diet (please check where appropriate)

- ☒ all meats
- ☒ mainly chicken/ fish
- ☒ soy products
- ☒ vegetarian
- ☒ variety of vegetables
- ☒ variety of fruits
- ☒ high grain
- ☒ dairy
- ☒ fried foods
- ☒ high carbohydrate
- ☒ low carbohydrate
- ☒ low fat
- ☒ low salt
- ☒ high protein
- ☒ spicy foods
- ☒ starches
- ☒ refined sugar
- ☒ artificial sugars
- ☒ water
- ☒ soda
- ☒ diet soda
- ☒ coffee
- ☒ tea
- ☒ fruit juice
- ☒ beer
- ☒ wine
- ☒ mixed drinks
- ☒ cook for self/ family
- ☒ fast food 4X/wk+
- ☒ eat out 3X/wk+

Please indicate if you have or have ever had any of the following:

Head, Eyes, Ears, Nose Throat

- ☒ glasses
- ☒ night blindness
- ☒ eye strain
- ☒ eye pain
- ☒ red eyes
- ☒ itchy eyes
- ☒ spot in eyes
- ☒ spots in vision
- ☒ blurred vision
- ☒ glaucoma
- ☒ cataracts
- ☒ nosebleeds
- ☒ ear ringing
- ☒ hearing loss
- ☒ earaches
- ☒ headaches
- ☒ migraines
- ☒ concussions
- ☒ throat drainage
- ☒ throat tickle
- ☒ sore throat
- ☒ swollen glands
- ☒ lump in throat
- ☒ enlarged thyroid
- ☒ teeth removed
- ☒ numerous cavities
- ☒ teeth grinding
- ☒ TMJ
- ☒ gum problems
- ☒ lib sores
- ☒ mouth sores
- ☒ excessive saliva
- ☒ facial pain
- ☒ facial numbness
- ☒ sinus problem
- ☒ sinus drainage

Respiratory

- ☒ difficulty breathing
- ☒ shortness of breath
- ☒ chronic cough
- ☒ acute cough
- ☒ tight chest
- ☒ asthma
- ☒ wheezing
- ☒ pneumonia
- ☒ pleurisy
- ☒ phlegm
- ☒ congestion
- ☒ rattling sound w/ breath
- ☒ can't sleep lying down

Cardiovascular

- ☒ hypertension
- ☒ chest pain
- ☒ palpitations
- ☒ blood clots
- ☒ rapid heart rate
- ☒ edema
- ☒ low blood pressure
- ☒ fainting
- ☒ irregular heart rate
- ☒ difficulty falling asleep
- ☒ difficulty staying asleep
- ☒ all night insomnia

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Gastrointestinal

- ☒ nausea
- ☒ vomiting
- ☒ acid regurgitation
- ☒ gas/flatulence
- ☒ hiccups
- ☒ bloating
- ☒ bad breath
- ☒ diarrhea
- ☒ constipation
- ☒ use laxatives
- ☒ use antacids
- ☒ use fiber
- ☒ use digestive enzymes
- ☒ intestinal pain
- ☒ very dark stools
- ☒ very light stools
- ☒ mucus in stools
- ☒ hemorrhoids
- ☒ rectal pain/itching
- ☒ fissures

Gastrointestinal cont.

- ☒ bowel movements 1X/ day
- ☒ smell with stool
- ☒ bowel movements less than 1X/day
- ☒ bowel movement greater than 1X/ day

Genito-urinary

- ☒ pain with urination
- ☒ frequent urination
- ☒ urgent urination
- ☒ incomplete urination
- ☒ blood in urine
- ☒ dribbling
- ☒ bed wetting
- ☒ frequent urinary infection
- ☒ edema
- ☒ increased libido (men)
- ☒ decreased libido (men
- ☒ impotence
- ☒ premature ejaculation
- ☒ nocturnal emissions
- ☒ sexually transmitted disease
- ☒ kidney stones
- ☒ urinate _____times per day
- ☒ wake to urinate _____ times per night
- ☒ urine odor
- ☒ dark color urine
- ☒ light color urine

Musculo-skeletal

- ☒ muscle weakness
- ☒ muscle cramps
- ☒ muscle spasms
- ☒ joint pain
- ☒ joint instability
- ☒ chronic pain
- ☒ acute pain
- ☒ muscular atrophy
- ☒ limited range of motion
- ☒ arthritis
- ☒ weather related pain
- ☒ general aches
- ☒ head
- ☒ shoulder/neck
- ☒ upper back
- ☒ mid back
- ☒ lower back
- ☒ hips
- ☒ upper legs
- ☒ ankles/feet
- ☒ arms
- ☒ wrist/hands
- ☒ other _____ _____

Neurophysiological

- ☒ depression
- ☒ irritable
- ☒ easily stressed
- ☒ easily frustrated
- ☒ worry easily
- ☒ anxious
- ☒ unresolved grief
- ☒ frighten easily
- ☒ numbness
- ☒ anger easily
- ☒ abuse survivor

- ☒ receiving counseling
- ☒ received counseling
- ☒ poor memory

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Skin and Hair

- ☒ rashes
- ☒ hives
- ☒ ulcerations
- ☒ eczema
- ☒ fungal infection
- ☒ psoriasis
- ☒ acne
- ☒ itching
- ☒ dandruff
- ☒ premature graying
- ☒ hair loss
- ☒ hair changes hair breaking
- ☒ thin slow growing nails
- ☒ skin dryness
- ☒ skin oily
- ☒ skin discoloration

Vitality and Immunity

- ☒ frequent colds
- ☒ frequent flu
- ☒ tender/achy all over
- ☒ chronic mental cloudiness
- ☒ less ability to adapt
- ☒ slow wound healing
- ☒ very low energy
- ☒ lethargic

Gynecology

- ☒ pregnant
- ☒ could be pregnant
- ☒ pregnancies # _____
- ☒ miscarriages # _____
- ☒ abortions # _____
- ☒ pre-mature births # _____
- ☒ use birth control pills
- ☒ use other means of birth control
- ☒ use no contraceptives
- ☒ use HRT
- ☒ menopausal
- ☒ peri-menopausal
- ☒ decreased libido
- ☒ increased libido
- ☒ PMS
- ☒ Pain before flow
- ☒ Pain during flow
- ☒ Bone density changes
- ☒ Fibrocystic breast
- ☒ Breast lumps
- ☒ Breast tenderness
- ☒ Mastectomy
- ☒ Lumpectomy
- ☒ Reg. self breast exams
- ☒ Hysterectomy when? _____
- ☒ Excess vaginal discharge - leucorrhea
- ☒ Vaginal odor
- ☒ Vaginal sores
- ☒ Vaginal dryness
- ☒ Vaginal itching
- ☒ Vaginal pain
- ☒ Spotting between cycles
- ☒ Blood clots
- ☒ Heavy bleeding – weeks
- ☒ Cycle absent
- ☒ Uterine fibroids
- ☒ Ovarian cysts

Age at Menarche (first period)? _____

Age at Menopause? _____

Date of Last PAP? _____

Date of last Mammography? _____

Current Menses:

Length of Cycle _____ # of days per month

Duration of Flow? _____# days of bleeding.

For practitioner's use only.

Tongue Body: _____
Tongue Coating: _____

Blood Pressure: _____

Pulse Rhythm:_____
Pulse Depth:_____
Pulse Rate:_____

Overall observation: _____

_____

For Patient Review Regarding Diagnostic Exam
Please sign one of the two options below:

Option One:

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

Patient Signature Date

Option 2:

I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

Patient Signature Date

Mary F. Dinneen, LAc., LMT Date

Preferred Health Solutions
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