Five Shen Wellness
Acupuncture Massage Therapy Herbal Remedies

Patient Intake Form

Thank you for coming in. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your information will be confidential. If you have questions, please ask. Thank You.

Full name		Sex ❒ F ❒ M	Date
Date of birth	Age	Occupation	
Main phone #		Other phone #	
E-mail address		Allow email contact by FSW	❒ Yes ❒ No
Emergency contact name & phone		Marital status	# of children
Address: Street		City State	Zip
Family physician		Chiropractor	
Do you have health insurance? ❒ Yes ❒ No	If yes, name of insurance company		
Does your insurance cover acupuncture? ❒ Yes ❒ No ❒ ?	Have you ever been treated by acupuncture before?		

How did you find out about our clinic? Friend / Relative (name)_____

☐ *Direct Mail* ☐ *Walk/Drive by Location* ☐ *Website* ☐ *Print Ad (please specify)*_____
☐ *Other (please specify)*_____

Main problem(s): _____

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

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Surgeries: _____**Hospitalization:** _____

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

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

Medications / Supplements (Prescription & Over the Counter) - SEE SEPARATE ATTACHED FORM

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Occupation: _____ Do you usually work ❒ indoors ❒ outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal: Height_____ Weight now_____ Weight one year ago_____

Weight maximum _____@Year _____

Habits: Do you smoke ? ❒ Yes ❒ No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes:_____

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? _____

Diet: How much coffee do you drink? _____cups/day Colas _____number/day Tea _____ cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? ❒ Yes ❒ No ❒ Yes, but not so strict Do you eat a lot of spicy food? ❒ Yes ❒ No

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

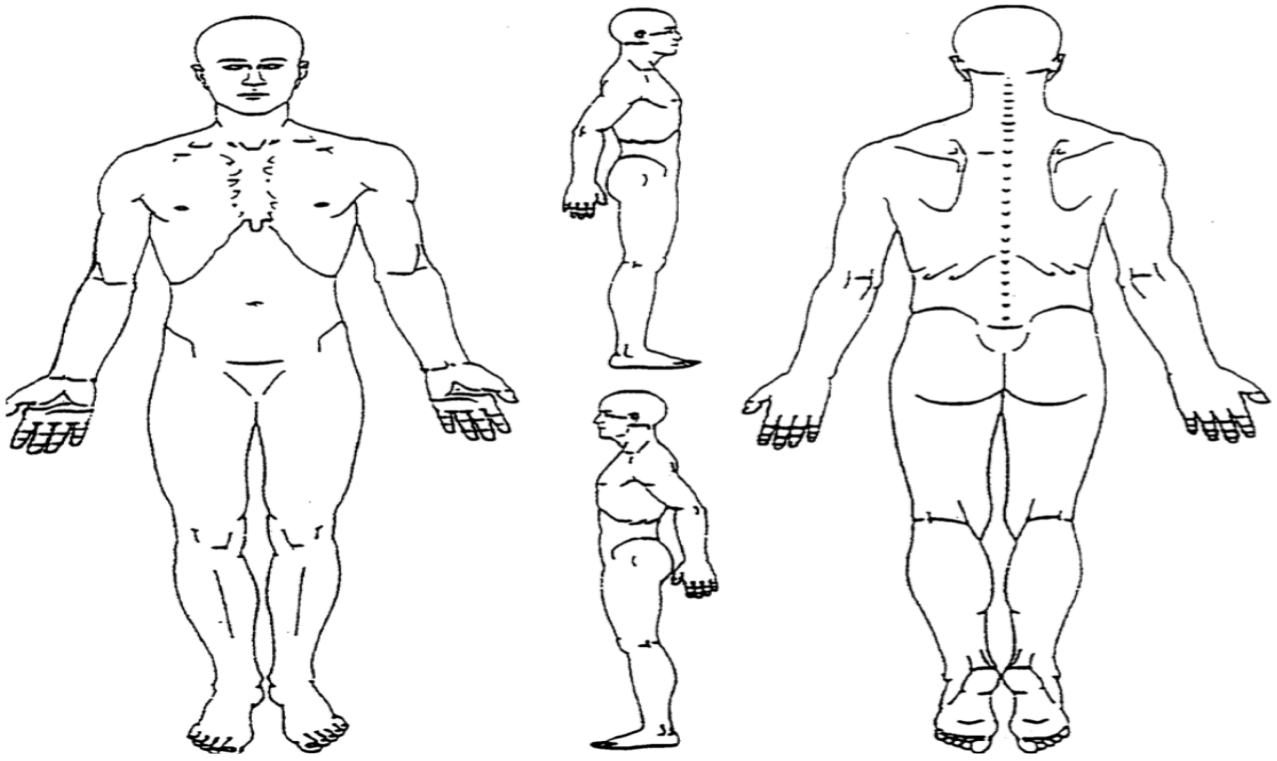
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



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

General: ❒ Poor appetite ❒ Poor sleep ❒ Fatigue ❒ Fevers ❒ Chills
❒ Night sweats ❒ Sweat easily ❒ Tremors ❒ Cravings ❒ Change in appetite
❒ Poor balance ❒ Bleed or bruise easily ❒ Localized weakness ❒ Weight loss ❒ Weight gain
❒ Peculiar tastes ❒ Desire hot food ❒ Desire cold food ❒ Strong thirst (cold or hot drinks)
❒ 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: ❒ Joint disorders ❒ Muscle weakness ❒ Pain/soreness in the muscles
❒ Cold hands/feet ❒ Difficulty walking ❒ Swelling of hands/feet ❒ Spinal curvature ❒ Hand/wrist pain
❒ Hernia ❒ Numbness ❒ Tingling ❒ Paralysis ❒ Neck pain ❒ Neck tightness
❒ Shoulder pain ❒ Back pain ❒ Hip pain ❒ Knee pain ❒ Joint sprain ❒ Tremors ❒ Other?

Head, eyes, ears, nose, & throat: ❒ Dizziness ❒ Concussions ❒ Migraines ❒ Eye strain
❒ Glasses/lens ❒ Eye pain ❒ Color blindness ❒ Night blindness ❒ Poor vision ❒ Cataracts ❒ Earaches
❒ Blurry vision ❒ Ringing in ears ❒ Poor hearing ❒ Spots in front of eyes ❒ Sinus problems ❒ Sore throat
❒ Nose bleeding ❒ 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 ❒ 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 ❒ Abdominal pain/cramps ❒ Gallbladder problems ❒ Parasites ❒ Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological: ❒ Loss of balance ❒ Lack of coordination ❒ Concussion
❒ Depression ❒Anxiety ❒ Stress ❒ Bad temper ❒ Bi-polar

Genito-urinary: ❒ Painful urination ❒ Frequent urination ❒ Blood in urine ❒ Urgency to urinate
❒ Kidney stones ❒ Unable to hold urine ❒ Pause of flow ❒ Dribbling ❒ Frequent urinary tract infection
❒ Genital pain ❒ Genital itching ❒ Genital rashes ❒ STD ❒ Other?

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Female:

❒ Frequent vaginal infections ❒ Pelvic infection ❒ Endometriosis
❒ Vaginal/genital discharge ❒ Fibroids ❒ Irregular periods ❒ Clots
❒ Pain/cramps prior/during periods ❒ Breast tenderness ❒ Breast Lumps ❒ Fertility Problems
❒ Hot flashes ❒ Moodiness related to periods ❒ Ovarian cysts
_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions
_____ Premature births _____ C-section _____ Difficult delivery
First date of last period _____ Age of first period _____
Duration of periods _____days, cycle ____ days
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? _____

Male:

❒ Prostate problems ❒ Discharge ❒ Erectile dysfunction ❒ Ejaculation problems
❒ Frequent seminal emission ❒ Fertility problems ❒ Painful/swollen testicles ❒ Other

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

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

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

Signature:_____ **Date**_____

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PRESCRIPTION MEDICATIONS

PRESCRIPTION MEDICATIONS: LIST ALL brand-name and generic prescription and over-the-counter medications currently taken.

Date ***started***	**Medication Name**	**Dose**	**How Often?**	**Reason for taking the medication**	**Date** ***stopped***

NONPRESCRIPTION MEDICATIONS, VITAMINS AND SUPPLEMENTS: LIST ALL those you take occasionally, such as aspirin for headache, as well as those you take every day, such as a multivitamin or nutritional supplement. Include any herbs or alternative medicines that you take.

Date ***started***	**Medication Name**	**Dose**	**How Often?**	**Reason for taking the medication**	**Date** ***stopped***