AcuPanda Intake Form

Name Last ____________First___________Middle___________ **Date of Birth** __/ __/ ____

Gender F M If Female, menses____

Email____ **Telephone** ___________________

Emergency contact Name _________________________ **Telephone** ___________________

Name of your physician __________________________ **Telephone**____________________

Occupation __________________________ **Referred by** __________________________

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

Main problem you would like us to help you with ______________________________________

How long did this problem begin?____

Have you been given a diagnosis for this problem? If so, what?____________________________

What kinds of treatment have you tried?____

Does anything improve problem?____

PAST MEDICAL HISTORY

Illnesses: ____

Surgeries: ____

Medicines: (prescription and OTC drugs, supplements, herbs. Taken within the last three months)

____

Allergies: ____

FAMILY MEDICAL HISTORY

Mother____

Father ____

PERSONAL HISTORY

Do you have a regular exercise program? No Yes, ___________________________

Please describe smoking or alcohol abuse: ____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

☐Fevers ☐Hot sensation ☐Tremors ☐Chills ☐Seizures ☐Fatigue ☐Stressful

☐Sudden energy drops If have, please describe happened in what time of day? _______________

☐Peculiar tastes or smells ☐Poor Balance ☐Bitter taste ☐Poor Memory ☐Easily Angered

☐Poor Sleep/ Insomnia ☐Difficulty Fall asleep ☐Tired when wake up ☐Dream Disturbed Sleep

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☐Day Sweating ☐Night Sweating ☐Prefer hot drinks ☐Prefer cold drinks ☐Depression

☐Weight Gain ☐Poor Appetite ☐Change in Appetite ☐Weight Loss ☐Localized Weakness

MUSCULOSKELETAL

☐Muscular Weakness ☐Muscular Atrophy ☐Muscular Recent Sprains ☐Muscle Cramps ☐Spasms

☐Injuries or Falls ☐Arthritis ☐Joint Instability ☐Joint Hot

☐Joint Pain, Describe (Which Joint, When Start): ____

CARDIOVASCULAR

☐High blood pressure ☐Dizziness ☐Headaches ☐Swelling of Hands ☐Blood Clots ☐ Anxiety

☐Irregular heartbeat ☐Fainting ☐Difficulty in Breathing ☐Palpitations ☐Low blood pressure

☐Cold Sweats ☐Cold Hands/Feet ☐Chest Pain/ Tightness ☐Swelling of Feet ☐Phlebitis

RESPIRATORY

☐Cough ☐Pain w/ Deep Breaths ☐Difficulty in Breathing ☐Asthma ☐Bronchitis

☐Shortness of Breath ☐Easily Sweating ☐Easily Winded w/ Exertion when laying down

☐Coughing Blood ☐Production of phlegm please describe the color of phlegm_______________

GASTROINTESTINAL

☐Abdominal Pain/ Cramps ☐Nausea ☐Vomiting ☐Indigestion ☐Belching ☐Ulcers ☐Bad Breath

☐Acid Reflux ☐Burning Sensation on Stomach ☐Often Gas ☐Poor Appetite ☐Constipation ☐Diarrhea

☐Blood in Stools

GENITO-URINARY

☐Pain on Urination ☐Decrease in Urine ☐Kidney sores ☐Urgent Urination ☐Blood in Urine

☐Waking up to Urinate ☐Frequent Urination ☐Impotency/ Infertility How often? _______________

☐Unable to Hold Urine ☐Genital Sores

PREGNANCY & GYNECOLOGY

Days between Menses__________ How many days duration of Menses

Vaginal Discharge, Color____

Irregular Periods Breast Lumps Vaginal Sores

Painful Periods Color__________________ Clots

First Date of Last Menstrual Cycle ____/_____/______

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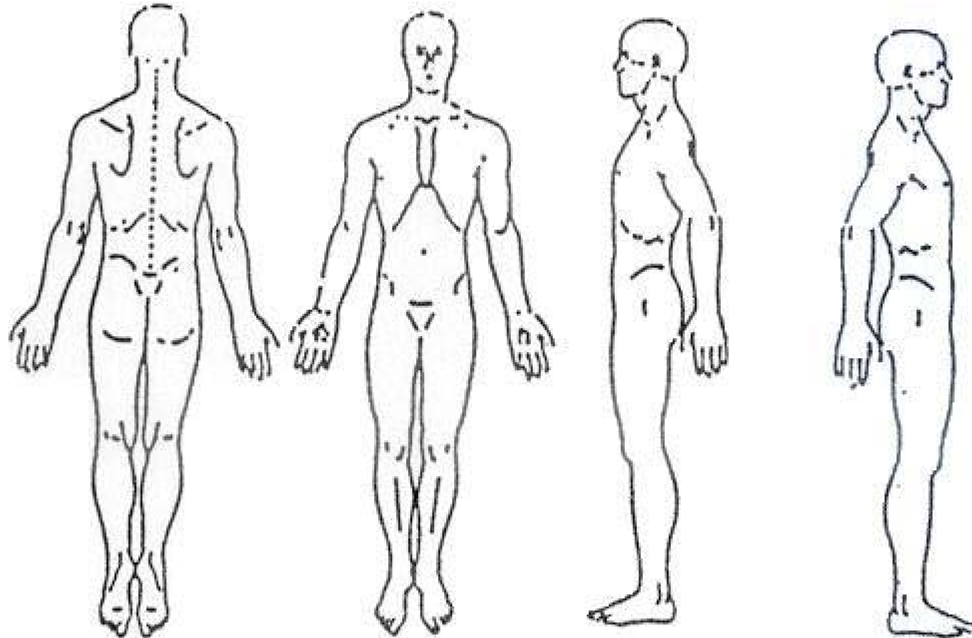
Please circle on the diagram any areas of any type of pain or injury:



Please try to describe the type of the pain ________________________________
Please circle a number that best describes the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain The most intense pain

Nature of the pain: ☐**Dull** ☐**Prickly** ☐**Sharp** ☐**Stabbing** ☐**Burning** ☐**Distention**

Projected to ____________________________________

Duration: ☐**Intermittent** ☐**Occasional** ☐**Continuous**

Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and Cupping etc. The risks, 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 (Parent or Guardian if under 18) **Date**