ICHS Intake Form

73 Montage Mountain Road, Moosic, PA 18507

Health History Questionnaire and Registration

Patient Information

Today's Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birthdate _____

Sex: ☐ Male ☐ Female

Occupation _____

Have you had Acupuncture before? ☐ Yes ☐ No

Primary physician _____

Physician phone number_____

How did you hear about us?_____

Contact Information

Home phone _____

Work phone _____

Other/Cell phone _____

Email _____

What is the best way to contact you? _____

Person we may contact in the case of an emergency:

Name _____

Relationship_____

Home phone _____

Work/Cell phone_____

Health History

What are the three main reasons for your visit today?

1) _____

When did this start? _____ago

Makes it *better:* ☐ Heat ☐ Cold ☐ Massage ☐ Rest ☐ Movement ☐ Other: _____

Makes it *worse:* ☐ Heat ☐ Cold ☐ Massage ☐ Rest ☐ Movement ☐ Other: _____

2) _____

When did this start? _____ago

Makes it *better*: ☐ Heat ☐ Cold ☐ Massage ☐ Rest ☐ Movement ☐ Other: _____

Makes it *worse*: ☐ Heat ☐ Cold ☐ Massage ☐ Rest ☐ Movement ☐ Other: _____

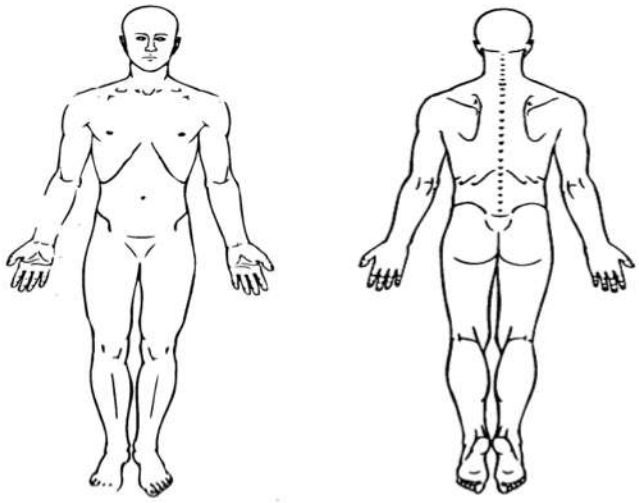
3) _____

When did this start? _____ago

Makes it *better*: ☐ Heat ☐ Cold ☐ Massage ☐ Rest ☐ Movement ☐ Other: _____

Makes it *worse*: ☐ Heat ☐ Cold ☐ Massage ☐ Rest ☐ Movement ☐ Other: _____

Please indicate any areas of pain or discomfort on the diagram below (if applicable):



Describe your pain: ☐ Dull ☐ Sharp ☐ Shooting ☐ Burning ☐ Stabbing ☐ Other: _____

Does the pain move or stay in the same location? _____

_____

Constant or does it come and go? _____

Is the pain affected by changes in the seasons or weather?

_____

_____

Do you have a special diet? (vegetarian, vegan, raw, Atkins, etc) _____

_____

Habits

	Amount per day	If Quit, Year?
Coffee/Tea		
Soda (including diet)		
Tobacco		
Alcohol		
Drugs		

Amount of water do you drink per day? _____ glasses

Do you exercise regularly? ☐ Yes ☐ No

If so, what and how often: _____

_____

What are your major causes of stress? (i.e. money, job, personal relationships, health) _____

_____

_____

What do you do to relax? _____

_____

List any recent medical exams/tests and their results:

_____

_____

_____

List medications or vitamin supplements you are taking and why (use back of sheet if needed): _____

_____

_____

_____

List serious illnesses, accidents or surgeries (note the year): _____

_____

_____

_____

_____

Conditions **you** have now or have had in the past:

- ☐ HIV/AIDS
- ☐ Allergies
- ☐ Thyroid disorder
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Hepatitis
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Latex Allergy
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Heart Disease
- ☐ Liver Disease
- ☐ Alcoholism
- ☐ Drug Dependence
- ☐ Mental Illness
- ☐ Asthma
- ☐ Kidney Disease

Other: _____

Illnesses that have occurred in **blood relatives**:

☐ Diabetes ☐ High blood pressure ☐ Stroke
☐ Cancer ☐ Heart disease ☐ Kidney disease
☐ Other serious conditions: _____

Check symptoms **you** have now or have had in the past:

TEMPERATURE

- ☐ Cold Hands/Feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness
- ☐ Thirst for cold drinks
- ☐ Absence of thirst
- ☐ Excessive thirst
- ☐ Unusual sweats
  When? _____ AM / PM
  Where on body?_____
- ☐ Night sweats
- ☐ Thirst for hot drinks
- ☐ Hot hands, feet, chest
- ☐ Hot flashes
  ☐ Day ☐ Night

MOISTURE

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry eyes
- ☐ Dry nails
- ☐ Dry nose/nosebleeds
- ☐ Edema/Swelling
- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples

SLEEP

# of hours of sleep per night _____

- ☐ Difficulty falling asleep
- ☐ Wake ____ x/ night @ _____ AM / PM
- ☐ Wake to urinate: How often? _____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

HEALTH HISTORY CONTINUED:

MUSCLE/JOINT/BONES

☐ Tremors ☐ Muscle cramps ☐ TMJ
☐ Swollen joints ☐ Broken bone(s)
☐ Neck Pain
☐ Frozen shoulder ☐ Tennis/golf elbow
☐ Muscle weakness ☐ Knee pain
☐ Low back pain
☐ Arthritis
☐ Carpal tunnel syndrome
☐ Other pain: _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

☐ Asthma ☐ Wheezing
☐ Difficulty breathing ☐ Persistent cough
☐ Earache ☐ Loss of hearing
☐ Enlarged glands ☐ Frequent colds
☐ Eye pain ☐ Blurred vision
☐ Hay fever ☐ Dental Problems
☐ Hoarseness ☐ Spots in front of eyes
☐ Gum trouble ☐ Mouth sores
☐ Ringing in ears ☐ Night blindness
☐ Sinus problems ☐ Phlegm(color _____)
☐ Headaches (Location:_____)

SKIN

☐ Boils ☐ Rashes ☐ Hair loss
☐ Bruise easily ☐ Psoriasis
☐ Sensitive skin ☐ Eczema
☐ Cuts that don't heal quickly

GENITO/URINARY

Urinate _____x/times per day
Color of urine? _____

☐ Blood in urine ☐ Pus in urine
☐ Frequent urination ☐ Painful urination
☐ Inability to control urine
☐ Kidney infections ☐ Kidney stones
☐ Lowered libido ☐ Increased libido

ENERGY

☐ Fatigue easily ☐ Poor memory
☐ Energy drop after eating ☐ Dizziness
☐ Body/limbs feel heavy ☐ Lightheaded
☐ Sudden energy drop
What time of day? _____ AM / PM

CARDIOVASCULAR

☐ Irregular heart beat ☐ Fainting
☐ Hardening of arteries ☐ Chest pain
☐ High blood pressure ☐ Low blood pressure
☐ Pace-maker ☐ Swelling of ankles
☐ Poor circulation ☐ Previous heart attack
☐ Rapid heart beat

EMOTIONAL

☐ Anger/Irritability ☐ Anxiety
☐ Depression ☐ Mood swings
☐ Seasonal Affective Disorder
☐ Panic attacks ☐ Mania
☐ Suicidal thoughts ☐ Other: _____

GASTROINTESTINAL

BM: How often? _____x/every _____days

☐ Belching ☐ Gas ☐ Bloating
☐ Constipation ☐ Diarrhea
☐ Difficulty swallowing
☐ Heartburn/Acid reflux ☐ Weight gain
☐ Excessive hunger ☐ Weight loss
☐ Gall bladder trouble ☐ Poor appetite
☐ Hemorrhoids ☐ Anorexia
☐ Bad Breath ☐ Vomiting
☐ Nausea ☐ Binge/Purge
☐ Pain over stomach

FOR MEN ONLY

☐ Erectile dysfunction ☐ Other:
☐ Prostate trouble _____

FOR WOMEN ONLY

Number of days between periods? _____days
Number of children? _____pregnancies_____

☐ Spotting between periods ☐ PMS
☐ Clots in menses ☐ Change in color/flow
☐ Excessive menstrual flow ☐ Scanty flow
☐ Extreme menstrual pain ☐ Irregular Cycle
☐ Birth Control Pills ☐ Previous miscarriage
☐ Vaginal discharge (color _____)
☐ Menopause When? _____
Symptoms: _____

Are you currently pregnant? ☐ Yes ☐ No
Any chance you could you be pregnant? ☐ Yes ☐ No
Are you trying to conceive? ☐ Yes ☐ No

SIGNATURE

Clients at Integrated Complementary Healthcare Specialists, ICHS, are advised by ICHS to consult a physician regarding the health conditions for which they are seeking acupuncture, TCM treatment, and massage. In Addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or show a new condition arise. Practitioners at ICHS do not diagnosis conditions other than within the scope of practice. By signing below I affirm and understand the above statement, and all the information provided in this form is accurate to the best of my knowledge.

Name(Print): _____Signature_____ Date _____