JENA LESAR, L.Ac.

Licensed Acupuncturist

Acupuncture Patient Intake Form

Information provided on this form is confidential. It is very important the information provided is complete and accurate to assist you properly in your healing process.

Contact Information Today's Date: _____/_____/_____

Name:_____Sex: ☐F ☐M DOB:_____/_____/_____Age:_____

Street:_____City:_____State:_____ Zip:_____

Email Address: _____

Primary phone Number:_____ ☐Cell ☐Home

Alternate phone Number:_____ ☐Cell ☐Home

Martial Status: ☐Married ☐Single ☐Living with Partner ☐Divorced ☐Widowed # of Children:_____

Occupation: _____

Emergency Contact/Relationship:_____ Phone:_____

Who is your Primary Care Physician? _____

Referrals are the best compliments. Whom may we thank for your referral? _____

Have you received acupuncture therapy before: ☐Yes ☐No

Current Health Complaints

What is your primary concern for which you are seeking care? (symptoms, diagnosis, and date of onset)

_____

_____

What other kinds of treatment have you tried for this condition? _____

What makes your condition better ? (movement, rest, heat, cold, eating, sleeping, etc.)

_____

What makes your condition worse ? (fatigue, stress, certain foods, times of day, heat, cold, hunger, etc.)

_____

Any other health concerns:

_____

_____

What goals do you have for your acupuncture treatments?

_____

_____

Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P	C		P	C		P	C		P	C	
☐	☐	Alcohol/Drug Abuse	☐	☐	Digestive Disorder	☐	☐	Hypertension	☐	☐	Nervous Disorder
☐	☐	Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Jaundice	☐	☐	Pneumonia
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Liver Disease	☐	☐	Thyroid Disorder
☐	☐	Auto Immune	☐	☐	Heavy Bleeding/Hemorrhage				☐	☐	Tuberculosis
☐	☐	Blood Transfusion	☐	☐	Hepatitis	☐	☐	Mental Illness	☐	☐	Vein Condition
☐	☐	Cancer	☐	☐	High Cholesterol	☐	☐	Migraines	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	HIV/Hepatitis	☐	☐	Other:_____			

Known allergies (food, medications, or other):_____

Significant trauma (car accident, sports injuries, emotional, etc.):_____

Hospitalizations/Surgeries (procedures and approx. dates):_____

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc.)

_____

Medications and supplements currently taking (prescription and over the counter) use other side if necessary

Name and dosage:	Taken For:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a pacemaker? ☐Y ☐N

Lifestyle

Do you exercise? ☐Y ☐N If yes, how many times per week?____ Please describe _____

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

I have difficulties with (check all that apply): ☐Falling asleep ☐Staying asleep ☐Dream-disturbed sleep

☐Waking up at about _____ am/pm and not being able to fall back asleep

How is your energy level? _____

On average, how many times a year are you sick? _____

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/black tea	☐	☐	_____	Tobacco	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda	☐	☐	_____

Please describe your average daily diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Foods you tend to crave:_____

Prefer cold or warm drinks: _____ Excessively thirsty? _____ ☐Anorexia ☐ Bulimia

Profile

Please check ✓ any symptoms you currently experience and star ★ ones you have had in the past.

☐Fatigue during the day	☐General Weakness	☐Easily Catches Colds	☐Shortness of breath
☐Feel worse after exercise	☐Prolonged recovery from illness		
☐Cold hands	☐Hot body temperature	☐Profuse perspiration	☐Chills
☐Cold feet	☐Cold body temperature	☐Lack of perspiration	☐Fever
☐Sweaty hands	☐Afternoon flushing	☐Perspire easily	☐Strong thirst
☐Sweaty feet	☐Hot flashes	☐Night sweating	☐Lower back pain
☐Palpitations	☐Fits of laughter	☐Panic attacks	☐Ever fainted
☐Chest pain or discomfort	☐Tongue ulcers	☐Trouble falling asleep	☐Restless dreams
☐Insomnia	☐Speech impediment	☐Mental restlessness	☐Hallucinations
☐Nasal dryness	☐Sore throat	☐Nose bleeds	☐Chest tightness
☐Wheezing	☐Difficulty breathing	☐Chest congestion	☐Dry mouth, nose, throat
☐Persistent cough	☐Asthma	☐Acne	☐Dry or Flaky Skin
☐Hives/Rashes	☐Ulcerations/Boils	☐Dandruff	☐Eczema
☐Psoriasis	☐Frequent colds/flu	☐Chronic Allergies (to:_____)	
☐Low appetite	☐Abrupt weight gain	☐Abrupt weight loss	☐Abdominal bloating
☐Hypoglycemia	☐Abdominal Gas	☐Fatigue after eating	☐Hernias
☐Prolapsed organs	☐Hemorrhoids	☐Easily bruised	☐Loose stools
☐Swollen hands	☐Mental fogginess	☐Edema in the legs	☐Heavy limbs/head
☐Swollen feet	☐Mental sluggishness	☐Edema in the abdomen	☐Joint stiffness
☐Large appetite	☐Indigestion	☐Belching	☐Nausea
☐Stomach ulcer	☐Bleeding gums	☐Vomiting	☐Heartburn
☐Hiccups	☐Mouth ulcers	☐Bad Breath	☐Acid Reflux/GERD
☐Blood in stools	☐Less than 1BM/day	☐Constipation	☐Diarrhea
☐Mucous in stools	☐Small, dry hard stools	☐Difficulty moving bowels	☐Cramping and pain
☐Undigested food in stool	☐Bowel movement: (#/day _____, or # wk_____)		
☐Tightness/pain in rib cage	☐Frequent sighing	☐Bitter taste in mouth	☐Lump in throat
☐Seizures	☐Lack of coordination	☐ Numbness	☐Tingling in extremities
☐Paralysis	☐Loss of balance	☐Muscle spasms	☐Migraines
☐Neck and shoulder tension	☐Gallstones	☐Red and irritated eyes	☐Watery eyes
☐Glaucoma	☐Blurred vision	☐Poor night vision	☐Cataracts
☐Glasses/contacts	☐High pitched ringing in ears	☐Floaters/sees spots	☐PMS
☐Headaches (where on head is pain? _____)			
☐Kidney stones	☐Urinary Tract Infections	☐Cold lower back	☐Low back pain
☐Cold knees	☐Weak, sore knees	☐Broken bones	☐Memory problems
☐Excessive hair loss	☐Early graying of hair	☐Need excessive sleep	☐Decreased motivation
☐Low pitched ringing in ears	☐Hearing loss	☐Frequent cavities	☐Broken/loose teeth
☐Urgent or frequent urination	☐Difficult or painful urination	☐Lack of bladder control	
☐Night-time urination	☐Dribbling		
☐Depression	☐Sadness	☐Grief	☐Emotional sensitivity
☐Obsessive-Compulsive	☐Mania	☐Overly worry	☐Easily startled
☐Anxiety	☐Anger easily	☐Frustration, irritability	☐Phobia or fears
☐Dizziness/lightheaded	☐Dry hair/skin/nails	☐Thin hair	☐Pale sallow complexion
☐Restless fatigue	☐Anxious sleep	☐Itchy skin	☐Muscle cramps
☐Dry stool	☐Anemia	☐Poor skin healing	

For Men

☐Prostate Problems	☐Testicular pain/swelling	☐Ejaculation problems
☐Decreased sex drive	☐Increased sex drive	☐Erectile dysfunction/impotence
☐Nocturnal emission	☐Back Pain	☐Feeling of coldness or numbness of genitalia
☐Rectal Dysfunction Discharge	☐Other _____	

For Women

☐ Irregular cycles	☐ Frequent vaginal infections	☐ Vaginal dryness	☐ Heavy or excessive flow
☐ Breast tenderness	☐ Abnormal vaginal discharge	☐ Low sex drive	☐ Pain during intercourse
☐ Breast lumps	☐ Spotting between periods	☐ Night sweats	☐ Hot flashes
☐ Postpartum depression	☐ Lack of breast milk		

Do you experience any of the following associated with your period each month?

☐ Water retention	☐ Migraine/headache	☐ Change in bowel movement	☐ Lower back pain
☐ Mood swings	☐ Irritability	☐ Abdominal cramps	☐ Food cravings
☐ Breast tenderness/swelling	☐ Acne	☐ Heavy bleeding	☐ Scanty/light bleeding
☐ Clots	☐ Other:_____		

Have you been diagnosed with: ☐ Fibroids ☐ Endometriosis ☐ Ovarian Cysts

At what age did you get your first period:_____ First day of last menstrual period:_____

Are your menstrual cycles spaced regularly? Y ☐ N ☐ Cycle length: _____ Period length : _____

If you are experiencing menopausal symptoms, please describe: _____

Is there <u>any</u> possibility you are pregnant now? Y ☐ N ☐

<u>Musculoskeletal</u>

I have : ☐ Swollen joints ☐ Arthritis/joint pain ☐ Tendonitis ☐ Bone pain ☐ Muscle cramping
☐ Muscle pain ☐ Repetitive Strain Injury ☐ Other: _____

I have received x-rays and/or a medical diagnosis for this condition? _____

Pain is Worse, Better or Neither (write W or B or N) with:

Heat_____ Cold_____ Pressure_____ Movement_____ Rest_____ Exercise_____ A.M._____ P.M._____

Other: _____

Pain Diagram

Please indicate painful or distressed areas by using the symbol that best describes the feeling:

A= aching **B= burning** **N=numbness** **P= pins and needles**

S= stabbing pain **O= other type of sensation**