

**AcuVanture Clinic Intake Form**

56 N Haddon Ave., Haddonfield NJ 08033

 Tel: 215-275-6990

**Name** Last-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_SSN #\_\_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**\_\_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ **Gender** F \_\_\_\_M \_\_\_\_\_ **Email** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Telephone:** Home (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_Ext.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Education** (Highest grade or degree achieved)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Option:** Height \_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_ HIV \_\_\_\_\_\_\_\_\_\_\_\_\_ HbsAg \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you been treated by Acupuncture or Oriental medicine before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of your physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Address of your physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_

In an Emergency Notify Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Day) (\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Evening) (\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

 1. Main problem you would like us to help you with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. How long ago did this problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. Have you been given a diagnosis for this problem? If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. What kinds of treatment have you tried? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. Are you currently receiving treatment for your problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 6. Does anything improve your problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PAST MEDICAL HISTORY

Illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Trauma (Auto accidents, falls, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Do you have, or have you ever had, any Infectious Diseases? Yes  No  If so, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicines** (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Allergies:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother’s Side\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Side\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Siblings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If any of the above is deceased, what was the cause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Childhood health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location of upbringing (Geographically prone to certain diseases, habits, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Emotional Health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Quality of Life\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Relationship/Quality\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Predominant Emotiom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Stress Level\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had any unusual stresses recently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Favorite time of year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worst\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies & Recreational Habits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have a regular exercise program? Yes  No  If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you traveled abroad in the past year? Yes  No  Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If applicable, please describe smoking or alcohol intake : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## NEUROPSYCHOLOGICAL

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   | Seizures  |  Areas of Numbness  |   |  Anxiety  |
|   | Concussion  |  Lack of Coordination  |   |  Poor Memory  |
|   | Dizziness  |  Loss of Balance  |   |  Easily Angered  |
|  |  |  |  |  |
|   | Headaches  |  Fainting  |   |  Depression  |
|   | Migraines  |  Disorientation  |   |  Mania  |
|   | Easily Susceptible to Stress  |  |  |  |

Have you ever been treated for emotional problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever considered or attempted suicide? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other neurological or psychological problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any nervous habits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PREGNANCY & GYNECOLOGY

|  |  |
| --- | --- |
| \_\_\_Age at First Menses  | \_\_\_ Number of Pregnancies  Birth Control?  |
| \_\_\_Period between Menses  | \_\_\_ Number of Births What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_Duration of Menses  | \_\_\_ Miscarriages How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  Unusual Character  | \_\_\_Abortions  Fertility Problems  |
|  Heavy or  Light  |  Difficult Births  Vaginal Discharge  |
|  Irregular Periods  |  Breast Lumps  Vaginal Sores  |
|  Painful Periods  |  Clots  |

First Date of Last Menstrual Cycle \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_ Date of Last Pap Smear \_\_\_\_\_\_/ \_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_

Do you experience changes in Body and/or Psyche prior to menstruation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEN ONLY**

 Impotence

 Vasectomy Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Prostate problems

 Testicular Pain/Redness/Swelling

 Low libido

 Excessive libido

 Seminal emissions

 Painful Intercourse

|  |  |  |
| --- | --- | --- |
| **GENERAL**  |  |  |
|  Fevers  |  Tremors  |  Change in Appetite  |
|  Chills  |  Seizures  |  Peculiar tastes or smells |
|  Fatigue What time of Day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Night Sweats  |  Sudden energy drops?  |
|  Poor Sleep/ Insomnia  |  Day Sweating  |  Strong thirst for Hot or Cold drinks?  |
|  Dream Disturbed Sleep  |  Poor Balance  |  Headaches |
|  Depression  |  Weight Loss  |  Localized Weakness |
|  Mania  |  Weight Gain  |  Bleeding or Bruising |
|  Emotional Changes **CARDIOVASCULAR**  |  Poor Appetite  |  Joint Pain |
|  High blood pressure  |  Dizziness  |  Swelling of Hands  Blood Clots  |
|  Irregular heartbeat  |  Fainting  |  Difficulty in Breathing  Palpitations |
|  Low blood pressure  |  Cold Sweats  |  Cold Hands/Feet  |
|  Chest pain **RESPIRATORY**  |  Swelling of Feet  |  Phlebitis  |   |
|  |  |
|  Cough  |  Pain w/ Deep Breaths  |   |  Difficulty in Breathing  |
|  Asthma  |  Bronchitis  |   |  Shortness of Breath  |
|  Easily Winded w/ Exertion when laying down  |   |  Coughing Blood |
|  Production of phlegm  **GASTROINTESTINAL**  |  What Color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Nausea  |   Abdominal Pain/ Cramps  |   |  Digestive Disorders  |
|  Vomiting  |   Parasites  |   |  Constipation |
|  Indigestion  |   Belching  |   |  Diarrhea |
|  Ulcers  |   Bad Breath  |   |  Blood in Stools  |
|  Hernia  **GENITO-URINARY**  |   Hemorrhoids  |  |  |
|  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  **MUSCULOSKELETAL**  |   Genital Sores |  |  |
|  Muscular Weakness  |   Arthritis  |   |  Recent Sprains  |
|  Muscle Cramps  |   Spasms  |  |  |
|  Injuries or Falls  |   Muscular Atrophy  |  |  |
|  General Aches  |   Joint Instability |  |  |

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



**Please try to describe the type and quality of the pain** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please use the scale below to tell us how intense your pain is, place a circle through the 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

Are there any other internal organ or systemic dysfunctions that we should be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other problems you would like to discuss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_