Melinda Acupuncture Clinic

39953 Balentine Drive Newark, CA 94560

Acupuncture Intake Form

Name____________________________Date of Birth__________ Gender: M__ F___

Address______________________City________________State_____Zip__________

Home phone________________________Cell_______________________________

E-mail address________________________________Occupation_________________

Emergency Contact: Name _______________________Phone____________________

Insurance:

Primary Insurance Company Name:_______________ID#__________________ GP#____________

Tel:___________________ Claim Address____

Secondary Insurance Company Name:_______________ID#_________________ GP#____________

Tel:____________________Claim Address ____

Work related injuries only:

Employer:_________________________________Date of Injury___________ SSN#_____________

Employer's address:____

Insurance Carrier___________________________________Claim Number:___________________

Please list and describe your major complaints:

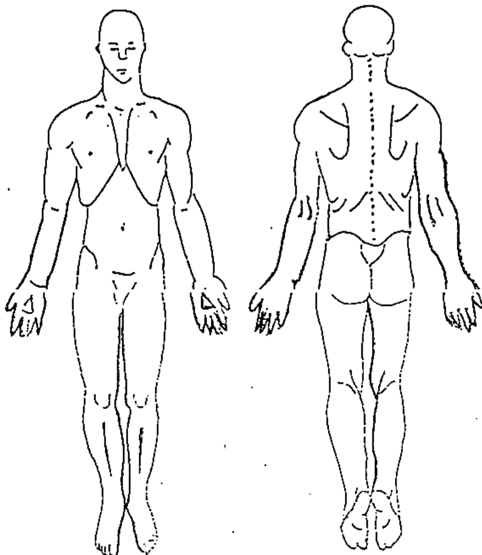
____

____

____

____

For pain symptom: please mark where you have pain on body chart and check the followings:



Pain scale:

No pain(0) 1 2 3 4 5 6 7 8 9 (10)unbearable

Pain description:

☐ Constantly ☐ Frequently ☐ Intermittently
☐ Occasionally ☐ Sharp ☐ Dull ☐ Stabbing
☐ Numbness ☐ Tingling ☐ Burning ☐ Stiffness
☐ Cold ☐ Hot ☐ Radiation to_____________

Alleviated (pain reduced) by:

☐ Massage ☐ Movement ☐ Cold pad ☐ Hot pad
☐ Rest ☐ Other______________________________

Aggravated (pain increased) by:

☐ Pressure ☐ Movement ☐ Seating ☐ Walking
☐ Lie down ☐ Hot ☐ Cold Other____________

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Personal health history:

☐ Hypertension ☐ Cancer ☐ Skin disorders
☐ Chest pain/pressure ☐ Arthritis ☐ Hepatitis
☐ Heart attack ☐ Digestive problems ☐ Memory Loss
☐ Shortness of breath ☐ Frequent urinary infections ☐ Cataracts
☐ Diabetes ☐ Anemia ☐ Glaucoma
☐ Headaches ☐ Ulcers ☐ Difficulty hearing
☐ Stroke ☐ Blood in stool ☐ Dizziness
☐ Depression ☐ TB/Lung disorder ☐ Allergies or Eczema
☐ Kidney disease ☐ Asthma ☐ HIV
☐ Alcohol/tobacco/drug dependence
☐ Hospitalization/surgical procedures____
☐ Medications____

Other:____

Family health history:

☐ Cancer ☐ Heart disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Asthma ☐ Arthritis
☐ Hepatitis ☐ Epilepsy/Convulsions ☐ Bleeding disorder r ☐ Lupus ☐ Thyroid Disease
☐ Other_________________________

For woman only:

Menstruation: ☐ Normal ☐ None ☐ Irregular: ☐ Late ☐ Early, Amount: ☐ Little ☐ Large
☐ Painful ☐ Low back pain ☐ Breast tenderness ☐Abdominal cramps

Discharge: Amount: ☐ Little ☐ Large Color: __________

History of Pregnancy: Pregnant: ☐ Yes ☐ No Planning to pregnancy ☐ Yes ☐ No
Number of pregnancies:______ Number of births:________
Abortion:_______ Miscarriage:_______

Life habits:

Sleep: ________hours /day Time to bed_______
☐ Difficulty falling asleep ☐ Early morning to awakening ☐ Continuity Disturbances
☐ Daytime drowsiness ☐ Snoring ☐ Other_________________________

Bowel movement: ______ /day, ☐ Constipation ☐ Loose Stool ☐ Diarrhea

Alcohol: Type___________________ Amount_________________

Coffee: Cups daily___________ Other Caffeine _________________

Smoke: How many daily_______________ Years ____________ Interested to quit?_________

Exercise Routine: ______________________________

On the scale of 1-10, how would you rate the level of stress in your life currently? ____________

Are there any other emotional disorder you would like to address and level of the disorder currently?

☐ Depression_______________ ☐ Mania /Vexation ____________ ☐ Anxiety________________
☐ Irritation /easy angry___________ ☐ Sadness_________________ ☐ Panics_____________

Are there any other concerns you would like to address?

____
____
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