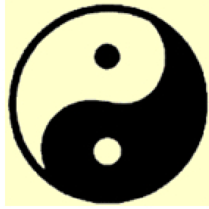


Li Zhang, L.AC, OMD, M.S.

Patient Intake Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full Name:		Sex: F M	Date:
Date of Birth:	Age:	Occupation:	S. S #
E-mail Address:	Home phone #		Work phone #
Address: Street		City	State Zip
In Emergency Notify:		Marital status S M D W	# of children
Family Physician:		Chiropractor:	
Do you have a health insurance? Yes No		Name of Insurance Company	
Does your insurance cover acupuncture? Yes No ?		Have you ever been treated by acupuncture before?	
How did you find out about this clinic? *Friends/Relatives* ________________ *Periodical* *Direct mail* *Location or Walk By* *Website* *Referred by*________________ *Yellow Pages* *Other (please specify)*			

Main problem(s) : You would like us to help you with ________________________________.

When did this problem begin? What are the precipitating factors?

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

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?

What kind of treatment have you tried?

What makes this problem worse? What makes this problem better?

Is there anybody in your family with the same/similar problems? Remarks and additional information:

Past Medical History (Please include the month/year when the diagnosis was established)

Significant illness:Cancer Diabetes Hepatitis Thyroid Disease Seizures
Fibromialgia Arthritis Tuberculosis Hypertension Emotional Imbalance Anemia
Breathing Problems Heart Disease Digestive Disorders HIV/AIDS Positive Veneral Disease
Other (pleased specify)

Surgeries: **Hospitalization:**

Significant trauma (auto accidents, sports injuries, etc) :

Allergies: (drugs, chemicals, foods)

Family medical history (Please specify family member) Cancer Diabetes Hepatitis
Hypertension Heart Disease Stroke Asthma Alcoholism Miscarriage Other (pleased specify)

Medicines taken within the last two months (including Vitamins, OTC drugs, herbs, etc., and their dosages)

Occupation Do you usually work: indoors outdoors ?

Occupational stress (chemical, physical, psychological, etc)

Personal Height___________ Weight now_____________ One year ago ________________________

Weight maximum ______________@Year _____________

Habits Do you smoke ? Yes No What? ______________ How many per day?__________ Since when? _________

Please describe any use of drugs for non-medical purposes:

Do you exercise regularly Yes No Please describe your exercise program:

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

Diet How much coffee do you drink ? _____cups/day ; Colas ______number/day; Tea _____cups/day.

What kind of alcoholic beverages do you usually drink? _________, average number of drinks/week ? _______

How much water do you drink per day? _______

Are you a vegetarian? Yes No Yes, but not so strict Do you eat a lot of spicy food ? Yes No

Remarks and additional information (e.g. diet)

Please describe your average daily diet (Please be as specific as possible):

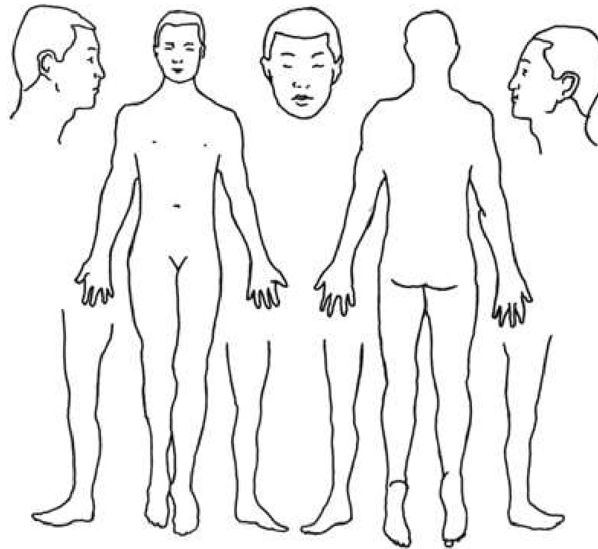
Morning

Afternoon

Evening

Snacks

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General Poor appetite Poor Sleeping Fatigue Fevers Chills
Night sweats Sweat easily Tremors Cravings Change in appetite
Poor balance Bleed or bruise easily Localized weakness Weight loss Weight gain
Peculiar tastes Desire hot food Desire cold food Strong thirst (cold or hot drinks)
Sudden energy drop (What time of a day) _________ Favorite time of year ___________ Worst time of year _________

Skin & hair Rashes Ulcerations Hives Itching Eczema
Pimples Dandruff Dry skin Recent moles Loss of hair Purpura
Change in hair or skin textures Other?

Musculoskeletal Joint disorders Muscle weakness Pain/soreness in the muscles Tremors
Difficult walking Cold hands/feet Swelling of hands/feet Back pain Spinal curvature Hernia
Numbness Tingling Paralysis Neck tightness Neck pain Shoulder pain
Hand/wrist pain Hip pain Knee pain Sprain of joint Other

Head, eyes, ears, nose, and throat Dizziness Concussions Migraines Glasses/lens
Eye strain Eye pain Color Blindnes Night blindness Poor vision Cataracts
Blurry vision Earaches Ringing in ears Poor hearing Spots in front of eyes Sinus problems
Nose bleeding Sore throat Grinding teeth Teeth problems Facial pain Jaw clicks
Sores on lips/tongue Difficulty swallowing Other

Cardiovascular High blood pressure Low blood pressure Chest pain Palpitation Fainting
Phlebitis Irregular heartbeat Rapid heartbeat Varicose veins Other

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Respiratory Cough Coughing blood Wheezing Difficulty in breathing Bronchitis
Pneumonia Chest pain Production of phlegm – What color? ______

Gastrointestinal Nausea Vomiting Diarrhea Constipation Gas Belching
Black stools Blood in stools Indigestion Bad breath Rectal pain Hemorrhoids
Abdominal pain/cramps Gallbladder problems Parasites Chronic laxative use
Bowel movements: Frequency _______ Color ______ Odor ______ Texture/ Form _______________

Neuro-psychological Loss of balance Lack of coordination Concussion Depression Anxiety
Stress Bad temper Bi-polar

Genito-urinary Pain on urination Frequent urination Blood in urine Urgent to urinate
Kidney stones Unable to hold urine Dribbling Pause of flow Frequent urinary tract infection
Pain in genital Itching of genital Other

Female Frequent vaginal infections Pelvic infection Endometriosis Vaginal/genital discharge
Fibroids Ovarian cysts Irregular periods Clots Pain/cramps prior/during periods
Breast tenderness Breast Lumps Fertility Problems Hot flashes Moodiness related to periods
______ number of pregnancies ______ number of births ______ Miscarriages ______ Abortions
______ Premature births ______ Cesareans ______ Difficult delivery

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First date of last period ________________ Age of first menses _____ Duration of periods ______days, cycle ____ days

Do you practice birth control ? Yes No . If yes, what type and for how long? ________________________________

If you're on birth control pills, what are you taking and for how long? ________________________________

Male Prostate problems Discharge Impotence Frequent seminal emission Fertility problems
Ejaculation problems Painful/swollen testicles Other

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: Adult Patient Parent or Guardian Spouse

Are there any other health issues you want to discuss with us?

Signature **Date**

Identification information update: **Date**
Name **Occupation** **Marital Status**
Email address **Phone**
Address
Insurance company
Other

Identification information update: **Date**
Name **Occupation** **Marital Status**
Email address **Phone**
Address
Insurance company
Other

Identification information update: **Date**
Name **Occupation** **Marital Status**
Email address **Phone**
Address
Insurance company
Other

Note