

# Acupuncture Intake Form

**Eight Elements West<sup>®</sup> Acupuncture or Chinese Herbal Medicine Consultation**

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*Important:* Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but may play a major role in your diagnosis and treatment.

*All information is strictly confidential.*

*Patient Name:* \_\_\_\_\_

*Email:* \_\_\_\_\_

<p><b>Address</b></p> <p>_____</p>	<p>Age _____ Birthdate _____ Date _____</p>																																
<p><b>HEALTH HISTORY</b></p> <p>What are your primary concerns for coming in for treatment? <i>List in order from greatest to least significant.</i></p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>How do these conditions impair your daily activities?</p> <p>_____</p> <p>_____</p> <p>What conditions significantly affected your health as a child</p> <p>_____</p> <p>_____</p>	<p>List medications or food supplements you are taking.</p> <p>_____</p> <p>_____</p> <p>For what conditions are they used? <i>(in respective order)</i></p> <p>_____</p> <p>_____</p> <p>Results: _____</p> <p>_____</p> <p>List serious illness, accidents or surgeries.</p> <p>_____</p> <p>_____</p>																																
<p>Check illnesses that have occurred in blood relatives:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Diabetes</td> <td style="width: 33%;">High Blood Pressure</td> <td style="width: 33%;">Stroke</td> </tr> <tr> <td>Cancer</td> <td>Kidney Disease</td> <td>Heart Disease</td> </tr> </table> <p>Check conditions you have or have had in the past:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Allergies</td> <td style="width: 50%;">Diabetes</td> </tr> <tr> <td>Anemia</td> <td>Heart Disease</td> </tr> <tr> <td>Arthritis</td> <td>High Blood Pressure</td> </tr> <tr> <td>Bleeding disorder</td> <td>Multiple Sclerosis</td> </tr> <tr> <td>Breast lump</td> <td>Stroke</td> </tr> <tr> <td>Cancer</td> <td>AIDS</td> </tr> </table>	Diabetes	High Blood Pressure	Stroke	Cancer	Kidney Disease	Heart Disease	Allergies	Diabetes	Anemia	Heart Disease	Arthritis	High Blood Pressure	Bleeding disorder	Multiple Sclerosis	Breast lump	Stroke	Cancer	AIDS	<p>Check symptoms you have or have had in the last year:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Depression</td> <td style="width: 50%;">Fatigue/tiredness</td> </tr> <tr> <td>Difficulty in focusing</td> <td>Headaches</td> </tr> <tr> <td>Dizziness</td> <td>Loss of sleep/poor sleep</td> </tr> <tr> <td>Easily startled</td> <td>Loss/gain of weight</td> </tr> <tr> <td>Excessive worry</td> <td>Nervousness</td> </tr> <tr> <td>Excessive anger</td> <td>Irritability</td> </tr> <tr> <td>Excessive fear</td> <td>Overwhelmed by life</td> </tr> </table>	Depression	Fatigue/tiredness	Difficulty in focusing	Headaches	Dizziness	Loss of sleep/poor sleep	Easily startled	Loss/gain of weight	Excessive worry	Nervousness	Excessive anger	Irritability	Excessive fear	Overwhelmed by life
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Check symptoms you have or have had in the past year:

**MUSCLE/JOINT/BONES**

- Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms
- Legs or Hips
- Feet
- Neck
- Hands
- Shoulders
- Other \_\_\_\_\_

**EYES/EAR/NOSE/THROAT/RESPIRATORY**

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

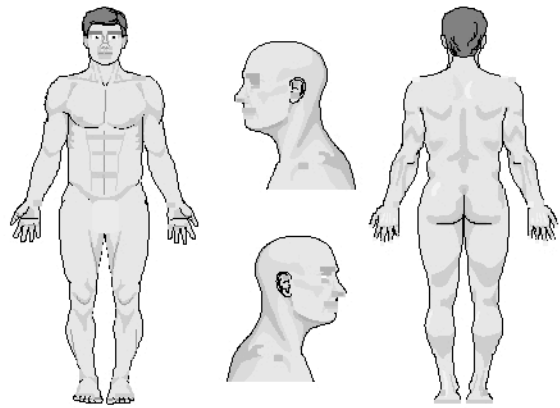
**SKIN**

- Boils
- Bruise easily
- Dry Skin
- Itching/rash
- Sensitive skin
- Sore that won't heal
- Sweats

**CARDIOVASCULAR**

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

On the figure below, please mark clearly any areas of pain



**GENITO/URINARY**

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stone
- Low/High libido

**GASTROINTESTINAL**

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Indigestion
- Nausea/Vomiting Pain over stomach
- Poor Appetite

**FOR MEN ONLY**

- Erection difficulties
- Prostate trouble
- Penile discharge

**FOR WOMEN ONLY**

- Bleeding between periods
- Excessive menstrual flow
- Extreme menstrual pain
- Menopausal symptoms
- Previous miscarriage
- Scanty menstrual flow
- Clots in menses
- PMS
- Irregular cycle

Could you be pregnant? \_\_\_\_\_

**SIGNATURE** *The information on this form is correct to the best of my knowledge.*

Signature: \_\_\_\_\_ Date \_\_\_\_\_