Intake Form
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www.integralacupuncturenashville.com

During your first visit or consultation, We hope to come to understand your health concerns, answer questions you may have and give you an examination or consultation using the Oriental medical approach. Then we will review the results together and look at options available for treatment of your condition. If you elect to undertake treatment, we will begin as soon as possible. Treatment often begins at one's first visit. Your treatment with us is meant to compliment and not replace your regular visits to your Primary Care Practitioner or traditional Western (allopathic) medicine.

PLEASE NOTE: ALL INFORMATION IS STRICTLY CONFIDENTIAL.
Some of the questions that follow may seem unrelated to your condition: they do however play a major role in diagnosis and successful treatment.

PLEASE PRINT

Name _____
Date _____/_____/_____

Address_____ City_____
State____ Zip_____

Country _____ Phone No. (____)_____
Work No. (____)_____

Email address:_____

Age:_____ Sex:____ Height ____'____" Weight _____lb.
Date Of Birth ____/____/___

Marital Status: _____Occupation _____
Employer _____

Party responsible for payment _____
In case of emergency notify _____

Their relationship to you_____
Their phone _____

How Did You Hear About This Office?_____
Diagnosing/Referring practitioner: _____

Please List The Main Health Problems You Would Like To Be Free Of In Order Of Importance:

1._____
_____

2._____
_____

3._____
_____

How And When Did These Conditions Begin?
_____

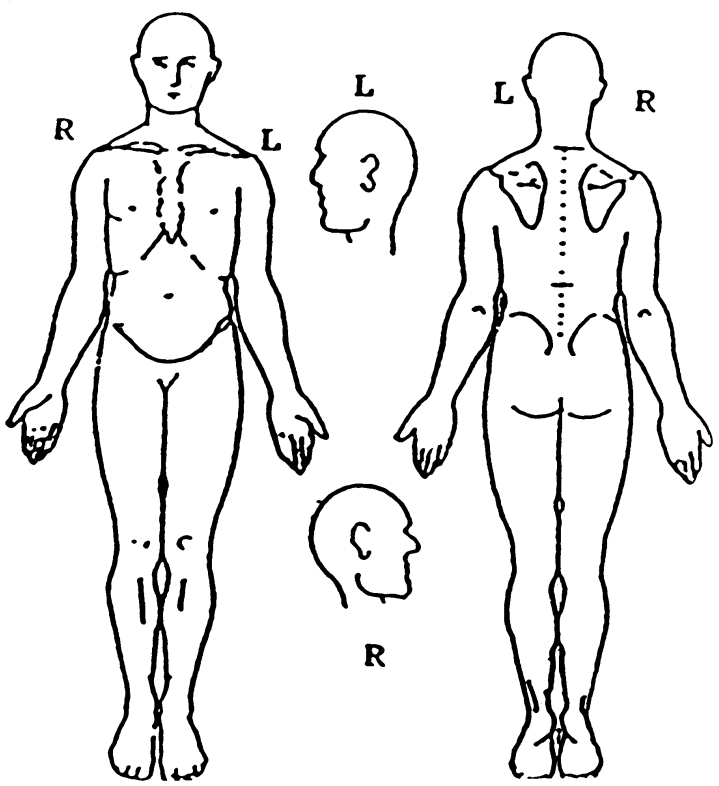
How Do They Impair Your Daily Activities?
_____

Health Professionals Seen for Them:
_____

Are you interested in additional health services besides acupuncture?
□yes □no

Please check which services you might be interested in:

- □ Chiropractic Services
- □ Chinese herbal medicine
- □ Assisted stretching/yoga
- □ Relaxation techniques
- □ Nutritional consultation
- □ Tai Chi and/or Qi gong health exercise



PLEASE MARK OR COLOR IN ALL AREAS OF PAIN OR DISCOMFORT, ON THE DIAGRAM ABOVE
Pain is: (check all that apply): Sharp [ ] Burning [ ] Moving [ ] Fixed [ ]
Dull [ ] Aching [ ] Stabbing [ ] radiates to:_____

Please check if you ever have had any of the following			
□	AIDS	□	Hives
□	Positive test for AIDS/HIV antibodies	□	Kidney stones
□	Blood transfusions	□	Kidney or bladder infection
□	Bone disease	□	Liver disease
□	Bronchitis	□	Low blood pressure
□	Bursitis	□	Lupus
□	Cancer or tumor	□	Malaria
□	Chicken pox	□	Measles
□	Colon/bowel disease	□	Mononucleosis
□	Allergies	□	Mumps
□	Anemia	□	Pancreatitis
□	Arthritis	□	Pleurisy
□	Asthma	□	Pneumonia

□	Diabetes		□	Polio
□	Diphtheria		□	Prostatitis
□	Drug habit		□	Rheumatic fever
□	Drug sensitivity or reaction		□	Scarlet fever
□	Emotional or mental problems		□	Small pox
□	Emphysema		□	Spinal meningitis
□	Gall stones		□	Stomach or duodenal ulcer
□	Gall bladder problems		□	Tendonitis
□	German measles		□	Tuberculosis
□	Heart trouble		□	Thyroid or goiter trouble
□	Heart murmur		□	Typhoid
□	Hemorrhoids		□	Venereal disease
□	Hepatitis/jaundice		□	Varicose veins
□	Herpes		□	Whooping cough
□	High blood pressure			

If you have had any of the following symptoms, check the box that tells us if the symptom was in the past or if it is current. Also, circle one of the numbers that appears to the right of the symptom.

(Circle 1 for the least severe, and 5 for the most severe.)

Past	Current	Symptom	1=least severe 5=most severe		Past	Current	Symptom	1=least severe 5=most severe
□	□	Abdominal/ stomach pain	1 2 3 4 5		□	□	Frequent or extended hoarseness	1 2 3 4 5
□	□	Always hungry	1 2 3 4 5		□	□	Hearing difficulties	1 2 3 4 5
□	□	Black stools	1 2 3 4 5		□	□	Nose bleeds	1 2 3 4 5
□	□	Constipation	1 2 3 4 5		□	□	Sinus problems	1 2 3 4 5
□	□	Diarrhea	1 2 3 4 5		□	□	Sore throats	1 2 3 4 5
□	□	Heartburn	1 2 3 4 5		□	□	Sounds/ringing in ears	1 2 3 4 5
□	□	Indigestion	1 2 3 4 5		□	□	Swollen glands	1 2 3 4 5

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
□	□	Gas	1 2 3 4 5	□	□	Trouble with your eyes	1 2 3 4 5
□	□	Lack of appetite	1 2 3 4 5	□	□	Unusual taste in mouth	1 2 3 4 5
□	□	Nausea	1 2 3 4 5	□	□	Dry skin	1 2 3 4 5
□	□	Overweight	1 2 3 4 5	□	□	Itching or burning skin	1 2 3 4 5
□	□	Unusually thirsty	1 2 3 4 5	□	□	Skin rash	1 2 3 4 5
□	□	Vomiting	1 2 3 4 5	□	□	Bloody urination	1 2 3 4 5
□	□	Weight changes	1 2 3 4 5	□	□	Burning urination	1 2 3 4 5
□	□	Bleeding easily	1 2 3 4 5	□	□	Difficult urination	1 2 3 4 5
□	□	Bleeding gums	1 2 3 4 5	□	□	Frequent urination	1 2 3 4 5
□	□	Bruising easily	1 2 3 4 5	□	□	Loss of bladder control	1 2 3 4 5
□	□	Chest pain or pressure	1 2 3 4 5	□	□	Painful urination	1 2 3 4 5
□	□	Dizzy spells or blackouts	1 2 3 4 5	□	□	Urination at night	1 2 3 4 5
□	□	Irregular heart beat	1 2 3 4 5	□	□	Concerns about sexual function	1 2 3 4 5
□	□	Poor circulation	1 2 3 4 5	□	□	Convulsions	1 2 3 4 5
□	□	Pounding heart beat	1 2 3 4 5	□	□	Depression	1 2 3 4 5
□	□	Racing heart beat	1 2 3 4 5	□	□	Fatigue or tiredness	1 2 3 4 5
□	□	Chest colds	1 2 3 4 5	□	□	Frequent or severe headache	1 2 3 4 5
□	□	Chronic cough	1 2 3 4 5	□	□	Difficulty getting to sleep	1 2 3 4 5
□	□	Congested nose	1 2 3 4 5	□	□	Difficulty staying asleep	1 2 3 4 5

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
□	□	Coughing up blood	1 2 3 4 5	□	□	Leg cramps	1 2 3 4 5
□	□	Smoking	1 2 3 4 5	□	□	Nervousness	1 2 3 4 5
□	□	Sneezing	1 2 3 4 5	□	□	Numbness or tingling	1 2 3 4 5
□	□	Wheezing	1 2 3 4 5	□	□	Shaking or trembling	1 2 3 4 5
□	□	Chills	1 2 3 4 5	□	□	Stuttering or stammering	1 2 3 4 5
□	□	Excessive sweating	1 2 3 4 5	□	□	Back trouble	1 2 3 4 5
□	□	Fever	1 2 3 4 5	□	□	Pain or swelling- any joint	1 2 3 4 5
□	□	Lack of perspiration	1 2 3 4 5	□	□	Painful feet	1 2 3 4 5
□	□	Night sweats	1 2 3 4 5	□	□	Painful muscles	1 2 3 4 5
□	□	Tendency to be too cold	1 2 3 4 5	□	□	Stiff or painful neck	1 2 3 4 5
□	□	Tendency to be too hot	1 2 3 4 5	□	□	Swelling of feet or legs	1 2 3 4 5
□	□	Earaches	1 2 3 4 5				

Other specific symptoms or illnesses you have had

Please list all surgeries & hospitalizations you've had

Please list your typical daily meals

List all current medicines or supplements

Check if you have family history of any of these					
□	AIDS	□	Diabetes	□	Mental illness
□	Allergies	□	Epilepsy	□	Problems with alcohol
□	Anemia	□	Glaucoma	□	Stroke
□	Arthritis	□	Gout	□	Thyroid disease
□	Asthma	□	Heart disease	□	Other potentially inheritable disease
□	Cancer	□	High blood pressure		

The Following Section is for Women

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
□	□	Abdominal pain or cramping with menstruation	1 2 3 4 5	□	□	Irregular periods	1 2 3 4 5
□	□	Abnormal PAP smear	1 2 3 4 5	□	□	I.U.D.	1 2 3 4 5
□	□	Abortion	1 2 3 4 5	□	□	Menopause	1 2 3 4 5

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
□	□	Back pain with menstruation	1 2 3 4 5	□	□	Miscarriage	1 2 3 4 5
□	□	Birth control pills	1 2 3 4 5	□	□	Premenstrual tension/ syndrome	1 2 3 4 5
□	□	Bleeding between periods	1 2 3 4 5	□	□	Vaginal dryness or itching	1 2 3 4 5
□	□	Bleeding during or after intercourse	1 2 3 4 5	□	□	Pregnancy	1 2 3 4 5
□	□	Bloating before periods	1 2 3 4 5	□	□	Scanty bleeding with period	1 2 3 4 5
□	□	Blood discharge from nipples	1 2 3 4 5	□	□	Tubal ligation	1 2 3 4 5
□	□	Breast lumps	1 2 3 4 5	□	□	Sickness/weakness with period	1 2 3 4 5
□	□	Heavy bleeding with period	1 2 3 4 5	□	□	Vaginal discharge	1 2 3 4 5
□	□	Hot flashes	1 2 3 4 5				
Duration of menstrual periods:							
Interval between periods:							
Dates of last period:							
Number of births you have had							
Ages of your children:							
Birth control method you use:							

You are responsible for full payment of your account in the form of cash or check at the time of service. (Any insurance reimbursement that may be possible is between you and your insurance company.)

Should you need to reschedule or cancel your appointment, please provide 24 hours' notice to avoid being charged.

Please sign below to acknowledge your acceptance o these polices and to certify that all information provided is true to the best of your knowledge. Thank you.

Signature: _____ Date: _____

Parent/Gaurdian Signature (if applicable) : _____