De'MEDICI
Classical Acupuncture

Michele de'Medici
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ACUPUNCTURE PATIENT INTAKE FORM

(Please fill out this form and bring with you to your first visit)

Name: _____ Date: _____

Address: _____City: _____State: _____ Zip: _____

Home phone: _____ work/cell: _____Marital Status: S M D W

Email: _____

Age: _____ Date of Birth: _____ Sex: M F

Emergency Contact Name_____ Phone: _____

Relationship: _____

Referral Source: _____

Family Physician: _____ phone: _____

_____

Patient Health History

Do you have any allergies? If applicable, please list any foods, drugs, or medications you have any sensitivity to or allergic to (Include any reactions; shortness of breathe, itching, etc.).

_____

_____

_____

_____

_____

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PATIENT HEALTH HISTORY (continued) Page 2

List any Medications, Vitamins, Herbs, or Supplements that you are currently taking, both over the counter or prescribed: (please include: Name/dosage/times).

Please list any Hospitalizations and/or Surgeries:

Reason	Date	Reason	Date

Women- Any chance you may be pregnant? Y N

Do you have any infectious diseases? Y N

List any significant Childhood Illnesses:

Respiratory System: (please circle conditions that you have experienced): Asthma; Emphysema; difficulty breathing Tuberculosis; Shortness of breath; frequent colds; other respiratory problems:

Cardiovascular System:(please circle any that you have experienced): Chest Pain; Heart Disease; Palpitations/Fluttering; Stroke; Rheumatic Fever; Varicose Veins; Hemorrhoids; Swelling of ankles; High Blood Pressure; Other cardiac problems:

Gastrointestinal System: (please circle any that you have experienced): Ulcers; Heartburn; Hepatitis B Hepatitis C; Nausea/Vomiting; Epigastric Pain; Abdominal Pain; Liver Disease; Belching/Bloating; Gas Pain; Gall Bladder Disease; Hungry all the time; Low appetite other concerns:

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PATIENT HEALTH HISTORY (continued) Page 3

Genitourinary System: (please circle any that you experience): Kidney Disease; Kidney Stones; Painful Urination; Frequent UTI's; Frequent Urination; Blood in the urine; other complaints:

Musculoskeletal System: (please circle any symptoms you have experienced): Neck/Shoulder Pain; Muscle Spasms/Cramps; Arm Pain; Upper back pain; Low back Pain; Leg Pain; Mid back Pain; any Joint Pain, if so please indicate the locations:

Neurological Disorders: (please circle any that you have experienced): Vertigo/Dizziness; Paralysis; Numbness/Tingling; Loss of Balance; Seizures/Epilepsy:

Endocrine System: (please circle any that you have experienced): Hypothyroid; Hyperthyroid; Diabetes Mellitus; Hypoglycemia; Night Sweats; Feeling Hot or Cold:

Other Medical condition (please circle any that you have experienced): Anemia; Cancer; Rashes; Eczema/ Hives; Cold Hands/Feet:

Females: Onset of Menses-age _____. Please list any difficulties with Menstruation, premenstrual symptoms, Menopausal Symptoms, bleeding, clotting, painful periods, vaginal discharges, difficulty conceiving. Please provide any details related to the specific issues you have had in past or are presently experiencing:

Males only: If applicable, Indicate any problems with: Sexual dysfunction; Prostrate Problems; Testicular Pain/Swelling; Penile discharge:

Is there anything else in your history that would be helpful for the practitioner to know?

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PATIENT HEALTH HISTORY (continued) Page 4

Do you have problems with any of the following?

Sleep: _____

Mood: _____

Depression: _____

Concentration: _____

Anxiety: _____

Family History:

Mother: Living/deceased: _____ Cause: _____

Father: Living/deceased: _____ Cause: _____

Siblings: living/deceased: _____ Cause: _____

Siblings: Living/deceased: _____ Cause: _____

Who do you Live with? Circle all that apply:

Self spouse children parents friends other; _____

What condition/Chief Complaint are you seeking Acupuncture Treatment for at this time?

Acute (up to 14 days)/ Chronic (over 14 days): _____

Onset: _____

Location: _____

Duration: _____

If you are presently experiencing pain? Describe the quality, onset, and location of the pain, in your own words.

_____

_____

_____

_____

_____

_____

_____

_____

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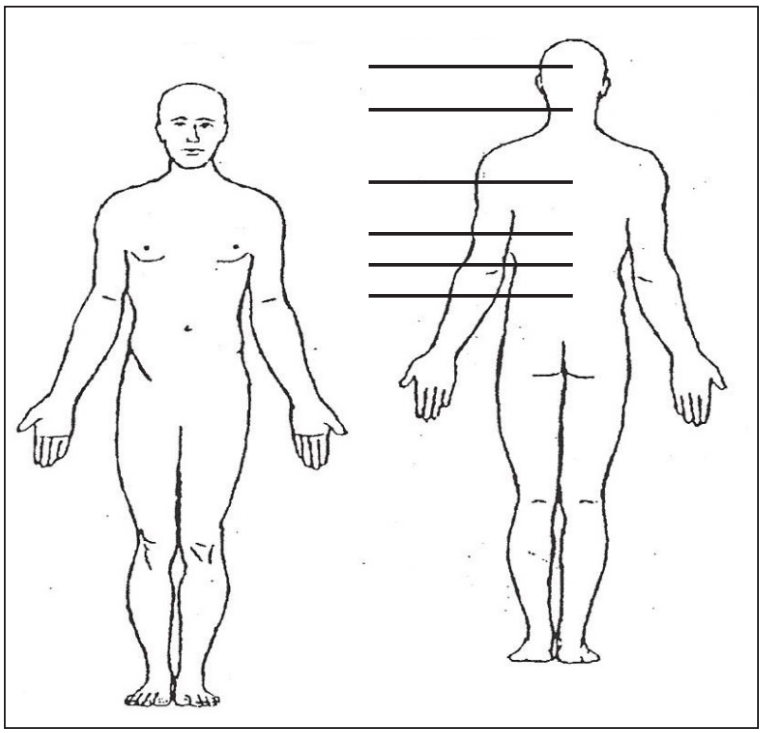
PATIENT HEALTH HISTORY (continued) Page 5

Please indicate any previous treatments you have tried for your pain and whether they helped your pain:

	YES	NO
Acupuncture	☐	☐
Chiropractor	☐	☐
Biofeedback	☐	☐
Traction	☐	☐
TENS Unit	☐	☐
Physical Therapy	☐	☐
Epidurals	☐	☐
Massage	☐	☐
Psychologist	☐	☐
Psychiatrist	☐	☐
Alternative Medicine	☐	☐
Surgery	☐	☐
Medications	☐	☐

Please indicate on drawing below with an (X) where you have discomfort.



What makes your pain worse:

☐ Sitting ☐ Standing ☐ Walking

☐ Bending ☐ Lying Down

☐ Driving ☐ Coughing/Sneezing

Please Indicate Your Consumption:

	None	Light	Moderate	Heavy
Salt	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Water	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____