Health Intake Form

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Please answer the following questions as you are able to. Some of the questions may or may not pertain to the particular health concerns you have today. This detailed intake form will help guide our in-person consultation.

First Name:_____ Last Name:_____
Preferred or Nickname: _____ Today's Date: _____/_____/_____
Address or area where you reside:_____
City: _____ State: ____ Zip: _____ Date of Birth:___/___/___ Age _____
Phone #: _____ Is it ok to leave a detailed voicemail? Circle: Yes/No
Email address: _____
Would you like emails from Burlwood Acupuncture? Circle: Yes/No
Gender Identity: _____ Preferred gender pronoun (she, he, they, etc.):_____
Emergency Contact Name:_____ Emergency Phone #: _____
Emergency Contact Relationship: _____ Health Insurance Plan: _____

Would you like to use your insurance to cover this appointment? Circle: Yes/No
If yes, please fill out the ***Insurance Verification Form***

For out-of-network plans:
Would you like a super bill to submit to your insurance? Circle: Yes/No

Main reason for visit (diagnoses, main complaints, symptoms):

Other health issues you would like to address:

What are your main goals with seeking this support?
1.
2.
3.

Current and past practitioners:
Please list any healthcare practitioners you have seen recently (within the past 2 years) and/or are currently seeing:

Western medical diagnosis known and date given (please bring in or email any significant labs):

Current medications (pharmaceuticals, herbs, vitamins):

Name	Dosage	Date Started

Please list any previous surgeries, hospital admittances, procedures, serious injuries and treatments, as well as the year in which they occurred:

<u>Immune System</u> *Mark any of the conditions below that pertain to you. Use 'P' for past problem and 'C' for current.*

__Adenitis
__Allergies
__Autoimmune disorders
__Catch everything
__Chronic fatigue
__Enlarged spleen
__Swollen lymph glands
__High white blood cell count
__Graves disease
__Hashimoto's thyroiditis
__Heal slowly
__Infections
__Immunodeficiency
__Low grade fever
__Sick often
__Multiple Sclerosis
__Lowered resistance
__Lupus (SLE)
__Mononucleosis
__Myasthenia gravis
__Pernicious anemia
__Rheumatoid arthritis
__Chronic sore throats
__Other:

Respiratory *Mark any of the conditions below that pertain to you. Use 'P' for past problem and 'C' for current.*

__Asthma
__Bronchitis
__Chest pain
__Common cold
__Coughing
__ Sneezing
__ Wheezing
__Other:
__Difficulty smelling
__Flu (influenza)
__Fluid in lungs
__Tight around lungs
__ Runny nose
__Trouble breathing out
__Trouble breathing in
__ Hay fever
__ Laryngitis
__ Pleuritis
__ Respiratory inflammation
__ Shortness of breath
__Stuffy nose
__Tuberculosis

Skin *Mark any of the conditions below that pertain to you. Use 'P' for past problem and 'C' for current.*

__Acne
__Boils
__Bruise easily
__ Dry hair
__Dry skin
__Eczema
__Slow to heal
__Impetigo
__ Itchy
__Moles
__Oily hair
__Oily skin
__Pimples
__ Psoriasis
__Hair loss
__Scars
__Skin tags
__Varicose veins
__Sensitive to chemicals
__Rashes
__Other:

Digestion *Mark any of the conditions below that pertain to you. Use 'P' for past problem and 'C' for current.*

__Anorexia nervosa
__Belching
__Bulimia
__Changes in bowel habits
__Crohn's disease
__Constipation
__Diarrhea
__Diverticulosis or Diverticulitis
__Dysentery
__Shigella
__Vomiting
__Gallstones
__Giardia
__Heartburn
__Hemorrhoids
__Indigestion
__Irritable bowel syndrome
__Pain before bowel movement
__Large appetite
__Sudden weight change
__Stomach aches
__Fistula
__Flatulence
__Eating disorders
__Food unappetizing
__Parasites
__Pain after eating
__Liver problems
__Nausea
__Low appetite
__Ulcer
__Ulcerative colitis
__ Other:

Describe your typical meals during the day:

Breakfast:

Lunch:

Dinner:

Snacks:

Describe any food intolerances or allergies:

Do you drink alcohol? How many drinks do you have per day___, week ___ or month___?

Mouth & Throat *Please list 'P' for previous or 'C' for current conditions.*

__Cavities	__Loose teeth	__Mouth sores
__Constant dryness	__Swollen tongue	__Oral herpes
__Difficultly swallowing	__Lip sores	__Painful/tight jaw
__Excess saliva	__Sore gums	__ Periodontal/gum disease
__Sore throats	__Swollen glands	__Other:

Ears *Mark any of the conditions below that pertain to you. Use 'P' for past problem and 'C' for current.*

__Ear infections	__Hearing loss	__ Overly sensitive
__Earaches	__Tinnitus/Ringing	__Wax build-up
__Other:		

Temperature and Regulatory Systems

Do you more often feel hot or cold? Do you frequently have hot flashes, night sweats, or low grade fever?
Do you have cold extremities? (arms, legs, hands, feet) Y/N
Do you frequently have sweaty palms or feet? Y/N

Memory

How is your long-term and short-term memory?
Has your memory changed noticeably in the past few years?

Eyesight

Are you near or far-sighted, do you wear corrective lenses?
Does the prescription for this change often?
Other eye issues:

Cardiovascular Health *Please list 'P' for previous or 'C' for current conditions. Put a ? if unsure.*

__Angina	__Congenital deformities	__Varicose veins
__Arrhythmias (irregular heartbeat)	__Palpitation	__Heart attack (myocardial infarction)
__Arteriosclerosis	__Stroke	__Fast heart beat (tachycardia)
__Black and blue easily	__Bleed easily	__Heart flutter
__Capillary fragility	__Heart irregularities	__Pericarditis
__Cardiac arrest	__ Heart murmur	__Ischemia
__Chest pains	__High blood pressure	__Congestive heart failure
__ Low blood pressure	__Edema	__Mitral valve prolapse
__Slow heart beat (bradycardia)	__Poor circulation	__Rheumatic fever
__Other**:**		

Cholesterol (if known list LDL, HDL and total cholesterol):

Have your blood pressure readings changed significantly over the last 5 years? If yes, how so?

Family History *Explain any significant family health history you would like to share:*

Nervous System and Stress

Please mark with 'P' for previously and 'C' currently to any conditions that are pertinent to you. ***Please also follow a scale of 1 (noticeable but not a big problem) to 5 (major problem).***

__ Anxiousness	__Hard to concentrate	__Fluctuating vision
__Bipolar	__Involuntary spasms	__Sudden mood swings
__Butterflies in stomach	__Mania	__Trouble falling asleep
__Cannot stay asleep	__Memory loss	__PTSD
__Constant feeling of stress	__Nervousness	__Twitching
__Diminished taste	__Numbness	__Worsening coordination
__Depression	__Pain – constant	__Psychosis
__Fear of facing a new day	__Panic attacks	__Seasonal affective disorder

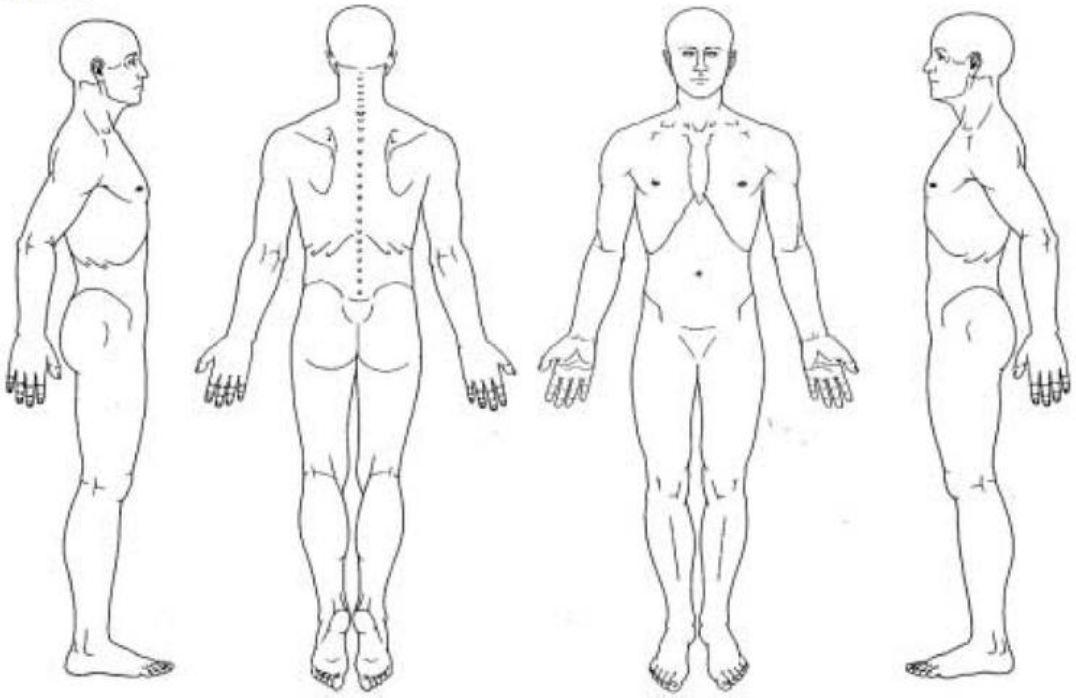
Describe your stress levels, what goes wrong with your body when stress levels are elevated?

Bladder and Kidney *Please list 'P' for previous or 'C' for current conditions. Put a ? if unsure.*

__Bloating	__Kidney/bladder stones	__Urinary tract infections
__Blood in urine	__Kidney pain	__Water retention
__Burning urination	__Lower back pain	__Bedwetting
__Frequent urge to urinate	__Strong smelling urine	__Other:

Pain *Are you currently experiencing pain? Circle: Yes/No*

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



Enviornmental *Please indicate if you have exposed to any of the following substances in a significant manner. List a 'P' for previous exposure and 'C' for current exposure.*

__Mold or mildew
__Pesticides/herbicides/fungicides
__Lead paint or pipes
__Cigarette smoke
__Wood smoke, wildfires or coal smoke
__Chemical inhalation
__Cleaning chemicals, solvents
__Dust, dust mites
__Ticks/tick bites
__Contaminated water
__Air pollution
__Radiation

Describe your work-place, volunteer, or other environment you spend significant amounts of time at:

Sexual Health *Please list 'P' for previous or 'C' for current conditions. Put a ? if unsure.*

__Genital herpes
__Candida
__Chlamydia
__Genital warts
__Crabs/lice
__Gardnerella/Bacteria vaginosis
__Gonorrhea
__ HPV
__Syphilis
__Trichomona
__HIV
__Other:

Gynecological (if applicable) *Please list 'P' for previous or 'C' for current conditions. Put a ? if unsure.*

Are you pregnant? Y/N *If Yes, how many weeks? ____*

__Breast pain
__Cervical dysplasia
__Endometriosis
__Infertility
__Painful intercourse
__Polycystic Ovary Syndrome (PCOS)
__Tumors in reproductive system
__Cysts
__Fibroids
__Miscarriage
__Pelvic inflammatory disease (PID)
__Abnormal PAP
__Vaginal discharge
__Pre-menopausal symptoms
__Hysterectomy
__Menopause
__Other:

Menstruation (if applicable)

Do you currently experience a menstrual cycle? Y/N Date of last menstrual cycle: ____/____/____
How often do you have a period? (Monthly, bi-monthly, irregularly, etc.) _____
How long does your period last? (2 days, 1 week, etc.) _____

One a 0-5 scale, list how painful or impactful any of the following symptoms are that you experience associated with menstruation:

__Cramps
__PMS
__Bloating
__Fatigue
__Heavy bleeding
__Other:
__Light bleeding
__Lower back pain
__Breaking out
__Pelvic pain
__Cravings
__Blood clotting
__Nausea
__Vomiting
__Irritability
__Depression

Reproductive (if applicable)

__Benign Prostatic Hyperplasia (BPH)
__Difficulty getting urine flowing
__ Frequent urination
__Libido low
__Penis pain
__ Blood in semen
__ Dribbling
__Impotence
__Painful ejaculation
__Prostate pain
__ Blood in urine
__ Erectile dysfunction
__Testicle pain
__ Painful to urinate
__Vitality low