Mercel Acupuncture & Herb

Client Intake Form

Thank you for coming. 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	
Main phone #		Other phone #	
E-mail address		Allow email contact by MAcH	Yes No
Emergency contact name & phone		Marital status	# of children
Address: Street		City State	Zip
Family physician		Chiropractor	
Do you have health insurance? Yes No If yes, 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 our clinic? Friends/Relatives(name)_____ *Direct mail* *Location or walk by* *Website* *Referred by*_____ *Yellow Pages* *Periodicals* *Other (please specify)*			

Main problem(s): _____.
What diagnosis, if any, have you received for this problem? _____
When did this problem begin? _____ What are the causes of this problem? _____
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:

Medical History

Diagnosis	Self Family	Diagnosis	Self Family	Self Family
Cancer		Breathing problems		Tuberculosis
Diabetes		Heart disease		High cholesterol
Hepatitis		Digestive disorders		High blood pressure
Thyroid disease		Venereal disease		Emotional disorders
Seizures		Alcoholism		Anemia
Arthritis		Depression or anxiety		Other:

Surgeries: _____Hospitalization: _____
Significant trauma: **(auto accidents, sports injuries, etc)**
_____
Allergies: (drugs, chemicals, foods, environmental):_____
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_____ Weight 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: _____

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How many hours do you sleep in general? _____ When time 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, if any? _____ 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):

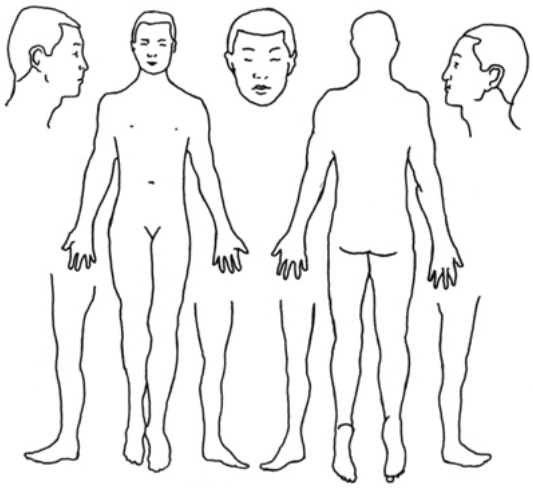
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



Please check if you have or have had (itions.

General: Poor appet Chills

Night sweats Sweat easily ite

Poor balance Bleed or bruise easily

Peculiar tastes Desire hot food hot drinks)

Sudden energy drop (What time of da _____ _____ of year _____

Skin & hair: Rashes Ulcerations Hives Itching Eczema

Pimples Acne Dandruff Dry skin Recent moles Loss of hair

Purpura Change in hair or skin texture Other?

Musculoskeletal: **Joint disorders** **Muscle weakness** **Pain/soreness in the muscles** **Tremors**

Cold hands/feet **Difficulty walking** **Swelling of hands/feet** **Spinal curvature** **Back pain** **Hernia** **Numbness** **Tingling** **Paralysis** **Neck tightness** **Neck pain** **Shoulder pain**

Hand/wrist pain Hip pain Knee pain Joint sprain Other?

Head, eyes, ears, nose, & throat: **Dizziness** **Concussions** **Migraines** **Glasses/lens** **Eye strain** **Eye pain** **Color blindness** **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?

Respiratory: Cough Coughing blood Wheezing Difficulty 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: Painful urination Frequent urination Blood in urine Urgency to urinate

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Genito-urinary: Painful urination Frequent urination Blood in urine Urgency to urinate

Kidney stones Unable to hold urine Dribbling Pause of flow Frequent urinary tract infection Genital pain Genital itching Genital rashes STD 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 _____ C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ 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 Erectile dysfunction Ejaculation problems

Frequent seminal emission Fertility problems Painful/swollen testicles Other

I have completed this form 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