GOOD MEDICINE

ACUPUNCTURE INITIAL INTAKE **TODAY'S DATE:**

Welcome to Good Medicine. Please fill out the following health history so that we know how to better help you at your first visit. All information is confidential.

Name:	Date of Birth:	Age:
Gender:	Occupation:	Employer:

When your health practitioners work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?

Physician:	Physician's Phone #:

Have you been treated with acupuncture or Chinese medicine before? If yes, please tell us briefly about your experience.

Yes:	This is my first time! (circle one) excited - nervous - skeptical - thrilled

Please write your top health concerns and indicate what makes it better or worse.

REASON FOR VISIT #1

Condition:	
When did this start:	Severity: (circle one) 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10

Let us know if you have noticed a difference with: (circle one)

HEAT	better	worse
COLD	better	worse
DAMP	better	worse
DRY	better	worse
ACTIVITY/EXERCISE	better	worse

REASON FOR VISIT #2

Condition:	
When did this start:	Severity: (circle one) 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10

Let us know if you have noticed a difference with: (circle one)

HEAT	better	worse
COLD	better	worse
DAMP	better	worse
DRY	better	worse
ACTIVITY/EXERCISE	better	worse

REASON FOR VISIT #3

Condition:	
When did this start:	Severity: (circle one) 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10

Let us know if you have noticed a difference with: (circle one)

HEAT	better	worse
COLD	better	worse
DAMP	better	worse
DRY	better	worse
ACTIVITY/EXERCISE	better	worse

HABITS Amount/Week - If Quit, what year?

Coffee _____
Tea _____
Tobacco _____
Alcohol _____
Drugs _____

EXERCISE

Do you exercise regularly?
If so, what and how often?

VITAMINS **MEDICATIONS**

SURGERY & HOSPITALIZATIONS

YEAR/REASON

Check the 'YOU' column if you have/had the condition. Check the 'FAMILY' column if you have a blood relative with this condition.

	You	Family		You	Family
Cancer			Allergies		
Diabetes			Asthma		
Heart			Kidney		
Blood Pressure			Thyroid Disorder		
Pacemaker			Anemia		
Stroke			Hepatitis		
Seizures			Alcoholism		
Osteoporosis			Mental Hx		

TEMPERATURE Do you run Hot or Cold?

Cold Hands/Feet	Thirst for Cold	Night Sweats	Hot Hands, Feet
Chills	Thirst for Hot	Unusual Sweats	Hot Flashes
Cold in the bones	Absence of Thirst	Hot in Afternoon	Hot at NIght
Numb Areas	Excessive Thirst		

MOISTURE How Dry/Oily is your overall body moisture (Hair, Skin, Mouth)

Dry Hair	Oily Hair	Dandruff	Dry Eyes
Dry Skin	Oily Skin	Dry Throat	Dry Nose/Bleeds?
Dry Mouth	Oily Mouth	Dampness	Dry or Brittle Nails
	Itching (Where?)	Edema/Swelling (Where?)	Rashes (Where?)

DIGESTION How is your digestion? Great Good Fair Poor BM's/Day_____

BM's Keep Shape	Diarrhea/Constipation	Bad Breath	Bloating
Difficult to Pass	Dry Stool	Heartburn	Tired after BM
Foul Smell	Poor Appetite	Excess Hunger	Foul Smell
Gas	Nausea/Vomiting	Indigestion	Hemorrhoids

ENERGY How is your general energy? Great Good Fair Poor

Sudden Drops in Energy	Body/Limbs Feel Heavy	Bleed/Bruise Easily
Energy Drops After Eating	Body/Limbs Feel Weak	Hard to Concentrate
Fatigue	Shortness of Breath	Poor Memory
Caffeine Dependence	Heart Palpitations	Dizzy/Lightheaded
Wired & Tired	Not Grounded	Headaches (How Many/Week?)

SLEEP How many hours/night _____ What time do you go to sleep_____

Difficult falling asleep	Restless Sleep	Not rested upon waking
Wake at night	Disturbing Dreams	Sleep is not deep
How often/What time?	Wake to urinate	Sleep too much

EMOTIONS What Emotions Dominate your experience?

Anger	Worry	Joy	Timid/Shy
Irritable	Obsessive	Depression	Indecision
Stress	Grief	Sadness	Worthless
Anxiety	Frustration	Panic	Happiness

EAR, EYES, NOSE, THROAT

Allergies	Spots in Eyes	Poor Hearing	Sore Throat
Asthma/Wheezing	Poor Vision	Ringing in Ears	Dental Problem
Sinus Congestion	Itchy Red Eyes	Excess Ear Wax	Mouth Sores
Phlegm (Color?)	Night Blindness	Catch Colds Easily	Persistant Cough

URINARY

Fluid intake roughly equals urination? Y / N

Decrease in flow	Blood in urine	Sores on Genitals
Dribbling	Burning sensation	Prostate Disorder
Pain on Urination	Cloudy Urine	Hernia
Urgency to urinate	Discharge	Erectile Dysfunction
Frequent Urination	Change in Sex Drive	Premature Ejaculation

WOMEN

MENSES

Day of Last Menstrual Period:	Do you track your cycle? Yes No If yes, how?
Age at First Menses:	Menstrual Flow: Heavy . Medium . Light
Length of Flow:	PMS: None . Some . Too Much
Are you Pregnant?	Cramps: Before . During . After
How many weeks?	Fatigue: Before . During . After
# of Pregnancies	Digestion/Hunter Changes
# of Abortions/Miscarriages	Mood Changes
Birth Control	Spotting
Irregular Periods	Clots
Yeast Infections	Painful Periods
Acne	Breast Tenderness

MENOPAUSE

Age at Last Menses	Night Sweats ___/day ___/night	Hot Flashes ___/day ___/night
Year Changes Began	Vaginal Dryness	Loss of Sex Drive

We encourage you to consult your medical doctor for any health problems for which you are seeking treatment.

SIGNATURE	**DATE**