RED & WHITE®
HOLISTIC HEALTHCARE CENTER, INC.

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Patient Intake Form

Name _____

Address _____

City _____ State_____ Zip _____

Home phone _____ Work/Cell phone _____

Email address_____

Birth date _____ Age_____Height_____Weight_____Sex _____

Marital status _____ Number and ages of children _____

Occupation _____

Employer's name and address _____

Personal physician_____

Date of last physical examination _____

Insurance company _____Policy # _____

Social security #_____ Driver's license # _____

In emergency:

Contact _____ Relationship _____ Phone _____

Referred by _____ Have you ever had acupuncture before? ❑ Yes ❑ No

Massage, acupressure, acupuncture, reflexology, ionic foot baths, preventative or corrective exercise, and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for western medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you consult your physician, for any serious conditions and get at least two medical opinions. It is your right and responsibility for your own body.

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

I understand that complications may result from acupuncture treatment. Among these possible complications are: Areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms.

Client further understands and agrees to hold harmless, to indemnify and protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

Signed:_____Date _____

MAJOR COMPLAINT (reason for visit): _____

Have you ever had this condition or similar condition before? ❑ Yes ❑ No

Have you ever received treatment for this condition? If yes, when? By whom?

_____

_____

What was the diagnosis? What were the results of the treatment?

_____

_____

Has the condition gotten: ❑ Better ❑ Worse ❑ About the same

What makes it better? _____

_____

_____

What makes it worse? _____

_____

_____

Describe what caused it or how it started:_____

_____

_____

FAMILY MEDICAL HISTORY:

❑ Cancer ❑ Diabetes ❑ High or low blood pressure ❑ Heart trouble ❑ TB ❑ Allergies ❑ Kidney disease
❑ Epilepsy ❑ Asthma ❑ Liver disease ❑ Ulcers ❑ Sinus problems ❑ Eye disease ❑ Arthritis ❑ Alcoholism
❑ Spinal problems ❑ Mental disorders ❑ Drug addiction ❑ Other _____

PERSONAL MEDICAL HISTORY
(Include date) Major surgeries, illnesses, diseases, accidents:

_____

_____

CONTAGIOUS DISEASES
(Check if you have ever had one of the following):

❑ HIV + ❑ AIDS ❑ Hepatitis ❑ Venereal disease ❑ Herpes ❑ Other _____

ALLERGIES
(Drugs, chemicals, food, animals, seasonal, etc.):

_____

_____

_____

Medications presently taking:

_____

_____

HABITS:

❑ Cigarettes ❑ Soft drinks ❑ Salt ❑ Coffee ❑ Alcohol ❑ Recreational drugs ❑ Black tea ❑ Sugar
❑ Stress ❑ Artificial sweeteners ❑ Marijuana ❑ Occupational hazards ❑ Other

EXERCISE:

❑ Never ❑ Little ❑ Moderate ❑ Heavy ❑ Type of exercise _____

EMOTIONS:

❑ Happy ❑ Easily irritable ❑ Difficulty making decisions ❑ Angry ❑ Cry easily ❑ Hurry to do things
❑ Depression ❑ Stressed ❑ Restless ❑ Other _____

DIET (Typical Foods):

❑ Beef ❑ Eggs ❑ Cheese ❑ Grains ❑ Tofu ❑ Pork ❑ Bread ❑ Margarine ❑ Fried foods ❑ Yogurt
❑ Poultry ❑ Milk ❑ Ice cream ❑ Sweets ❑ Health foods ❑ Fish ❑ Butter ❑ Vegetables ❑ Salads
❑ Hot spicy food ❑ Other _____

APPETITE:

❑ Up and down ❑ Poor ❑ Good ❑ Hungry a lot ❑ Loss of taste
Do you eat three meals per day: ❑ Yes ❑ No Do you eat at regular hours? ❑ Yes ❑ No

Cravings _____

WEIGHT:
❑ Normal ❑ Underweight ❑ Overweight ❑ Recent gain ❑ Recent loss

ENERGY:
❑ Up and down ❑ Low ❑ Normal ❑ Excess ❑ Low after eating
❑ Tired in the afternoon ❑ Other _____

BODY TEMPERATURE:
❑ Warm natured ❑ Flushed face ❑ Feel warmer late afternoon and night ❑ Sweat easily ❑ Night sweats
❑ Cold natured ❑ Warm palms ❑ Alternate chills and fever ❑ Profuse perspiration
❑ Cold hands and feet ❑ Warm soles ❑ Normal ❑ Other _____

DIGESTION:
❑ Indigestion ❑ Bloating ❑ Heartburn ❑ Nausea ❑ Vomiting ❑ Full feeling or distention ❑ Belch or burp
❑ Abdominal pain or cramps ❑ Gas ❑ Difficulty digesting fatty or oily foods ❑ Bitter taste in mouth ❑ Gallstones
❑ Normal ❑ Other _____

BOWELS:
❑ Loose stool ❑ Diarrhea ❑ Hemorrhoids ❑ Constipation ❑ Colon problems ❑ Pain or cramps ❑ Use laxatives
❑ Normal ❑ Other _____

URINATION (three to four times per day is normal):
❑ Frequent ❑ Burning ❑ Bladder infections ❑ Urgency ❑ Nighttime ❑ Incontinence
❑ Kidney stones or infections ❑ Normal ❑ Other _____

THIRST:
❑ Less than normal ❑ Prefer cold drinks ❑ Thirsty, but do not drink ❑ Prefer hot drinks # per day _____
❑ Excessive ❑ Normal ❑ Other _____

SLEEP:
❑ Difficulty falling asleep ❑ Lots of dreams ❑ Tired upon rising ❑ Awake easily ❑ Nightmares
❑ Sleep too much ❑ Difficulty going back to sleep ❑ Restless ❑ Normal ❑ Average number of hours a night _____
❑ Other _____

HEADACHES - DIZZINESS:
❑ Headaches ❑ Vertigo ❑ Bend down and stand up and get dizzy ❑ Dizziness ❑ Motion sickness
❑ Poor balance ❑ Faint easily ❑ Migraines ❑ Poor memory ❑ Other_____

SKIN:
❑ Dry ❑ Hives ❑ Itching ❑ Oily ❑ Acne ❑ Bruise easily ❑ Eczema ❑ Normal
❑ Rashes ❑ Cuts heal slowly ❑ Other _____

HAIR:
❑ Dry ❑ Oily ❑ Dandruff ❑ Falling out ❑ Prematurely grey ❑ Normal ❑ Other _____

NAILS:
❑ Soft ❑ Spots ❑ Grow slowly ❑ Ridges and lines ❑ Purple ❑ Normal
❑ Break easily ❑ Pale ❑ Grow fast ❑ Other_____

EYES:
❑ Wear glasses or contacts ❑ Eyelids swollen ❑ Red ❑ Dry ❑ Itch ❑ Poor night vision ❑ Twitch ❑ Pain
❑ Sensitive to light ❑ Color blindness ❑ Tear easily ❑ Normal ❑ Other _____

EARS:
❑ Poor hearing ❑ Ringing (high pitch) ❑ Ringing (low pitch) ❑ Discharges ❑ Ear aches ❑ Normal
❑ Other _____

NOSE:
❑ Stuffy nose ❑ Hayfever ❑ Sneeze a lot ❑ Environmental sensitivity ❑ Mucous ❑ Bleeding ❑ Loss of smell
❑ Blow nose a lot ❑ Sinusitis ❑ Rhinitis ❑ Normal ❑ Other _____

MOUTH & THROAT:
❑ Dry ❑ Gum problems ❑ Frequent colds ❑ Difficulty swallowing ❑ TMJ ❑ Feel lump in throat
❑ Thyroid problems ❑ Grind teeth ❑ Normal ❑ Other_____

RESPIRATORY:
❑ Shortness of breath ❑ Difficulty inhaling ❑ Sigh a lot ❑ Chest pain ❑ Difficulty exhaling ❑ Dry cough
❑ Asthma ❑ Difficulty breathing ❑ Cough with phlegm ❑ Bronchitis ❑ Emphysema ❑ Cough with blood
❑ Tightness in chest ❑ Wheezing ❑ Normal ❑ Other _____

CARDIOVASCULAR - CIRCULATION

❑ Diagnosed heart problems ❑ Palpitations ❑ Low blood pressure ❑ Bleed easily ❑ High blood pressure
❑ High cholesterol ❑ Murmur ❑ Varicose veins ❑ Ankle/Hand swelling ❑ Chest pain ❑ Bruise easily
❑ Irregular heart beat ❑ Numbness in extremities ❑ Normal ❑ Other_____

PAIN:

❑ Low back ❑ Shoulder ❑ Muscle weakness ❑ Sciatica ❑ Hands or wrists ❑ Muscle cramps
❑ Upper back ❑ Hips ❑ Muscle twitching or spasm ❑ Mid back ❑ Knees ❑ Damp weather
❑ Neck ❑ Foot or ankle ❑ Nerve ❑ Spine ❑ Arthritis ❑ Flank area ❑ Other _____

ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS?

_____
_____

* * * * * * * FOR FEMALES ONLY (If you are female, please continue filling out the remainder of the form) * * * * * * *

Are you or might you be pregnant? ❑ Yes ❑ No ❑ Maybe If yes, approximate date of conception?_____

Are you experiencing reduced sex drive? ❑ Yes ❑ No Other difficulties? Explain: _____
_____

Do you have regular pap tests? ❑ Yes ❑ No How regular? _____

Do you have regular breast exams? ❑ Yes ❑ No How regular? _____

Do you have facial hair or excess body hair? ❑ Yes ❑ No

MENSTRUAL CYCLE:
(Please check and explain as applicable)
Age started _____ Days of flow _____ Age stopped _____

How many days from the beginning of your period to the start of your next period? _____

❑ Irregular Painful ❑ Heavy flow ❑ Scanty flow ❑ Dark Color flow ❑ Light color flow ❑ Clotting
❑ Water Retention ❑ Abdominal bloating ❑ Painful or tender breasts ❑ Breast lumps ❑ Emotional changes
❑ Spotting between periods ❑ Lump in throat feeling ❑ Constipation and/or diarrhea ❑ Tightness in chest
❑ Hormonal problems ❑ Backache ❑ Sigh a lot ❑ Other _____

VAGINAL DISCHARGES:

❑ Yellow ❑ Thick ❑ Bad odor ❑ White ❑ Clear ❑ Other _____

OVULATION SYMPTOMS:

_____
_____

MENOPAUSE PROBLEMS?

_____
_____

PREGNANCIES:

Total number _____ Number of miscarriages _____ Number of children _____ Number of therapeutic abortions _____

PREGNANCY OR CHILDBIRTH COMPLICATIONS:

_____
_____

GYNECOLOGICAL HISTORY AND OPERATIONS

❑ Ovaries _____
❑ Uterus _____
❑ Fallopian tubes _____
❑ Vagina _____
❑ Breasts _____
❑ Other _____

What method of birth control do you now use?

_____

What method of birth control have you used in the past?

_____
_____