



Group Acupuncture Initial Intake

Name (print) _____ Visit Date _____

- Please indicate if any of the following pertain to you (marking “yes” does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

- Pregnancy Cancer pacemaker Diabetes Hepatitis
 Seizures Stroke HIV/AIDS High blood pressure
 Blood-Thinning Meds Sexual Transmitted Diseases
 Emotional disorders infectious diseases

Allergies:

- **History of Substance use:**

Tobacco _____ per day, for _____ years. Coffee/Black tea _____
 Alcohol _____ Others _____

- **Current Complaint (please identify your major health concern)**

- **History of Present Illness**

How did this health issue come about?

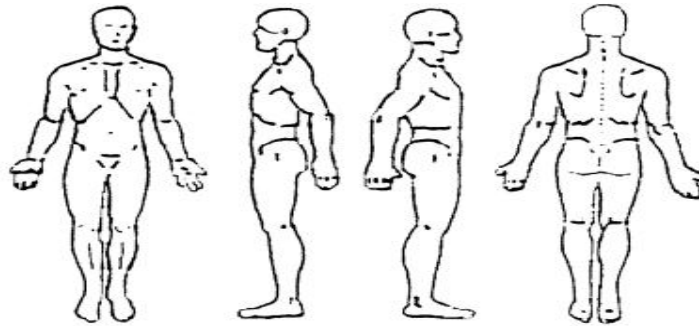
How long have you had it?

What medical diagnosis have you received for this condition?

What other treatments have you received for this condition? Did those treatment work for you?

- **Past Surgeries (please write surgery year as well)**

- **Pain Patients**, please indicate on the figures below the areas of body you experience your pain:



- **Review of Systems:**

General

Energy _____

Sleep _____

Sweat _____

Sensitive to Temperature change _____

usually feel warm usually feel chilled

Recent weight loss/gain _____

Emotions _____

panic attacks Depression Anxiety
 Bad temper Nervousness Poor memory
 Difficult concentration

Pain Patients _____

Pain character dull/achy sharp/stabbing burning
 tingling numbness electrical

Sp/St

Appetite _____

Digestive problems _____

Others _____

Ht/P

Palpitations Others _____

Lu/LI

Cough _____

Shortness of breath _____

Nasal problems _____

Tao Institute Mind & Body Medicine

Skin problems _____

Bowel Movement _____

Others _____

Ki/UB

Low back pain _____

Joint problems _____

Edema _____

Urinary problems _____

Others _____

Liv/GB

Easily angered _____

Difficulty in making decisions _____

Bitter taste _____ Dizziness _____

High cholesterol _____ Eye problems _____

Others _____

Women

Date of first period _____ Date of last period _____

Number of days between cycles _____

Flow _____

Color _____

Pain _____

Number of pregnancies _____ Miscarriages _____ Birth control _____

Vaginal discharge _____

Others _____

Have you ever been diagnosed with

endometriosis ovarian cysts fibroids STD

fibrocystic breasts polycystic ovary syndrome PID

Men

Prostate problem _____

Impotence _____

Others _____

Patient Signature _____

PAY ATTENTION: THIS PAGE IS FILL BY DOCTOR ONLY

Tongue

Color _____ Coat _____

Shape _____

Pulse _____

TCM Diagnosis

Treatment Plan

Herbal Supplement

Acupuncture

Head _____

Ear _____

Left _____

Right _____

Abdomen _____

Moxa _____

Cupping _____

***** Special Cautions**

*****Next plan**
