LONGEVITY & WELLNESS ACUPUNCTURE

Acupuncture Intake Form

Today's Date: ____/____/____

Patient Name: _____ DOB: _____/_____/_____

Reason for Visit/Current Pain or Symptoms:

_____

_____

_____

Chief Complaint: *Code of Virginia* §54.1-2956.9, 18 VAC 85-110-10 requires a recent (6mo) Western medical diagnostic exam documentation (including CBC and labs). **On file:** Yes/No

1.)_____

2.)_____

3)_____

Pain Location:_____

Headache:_____

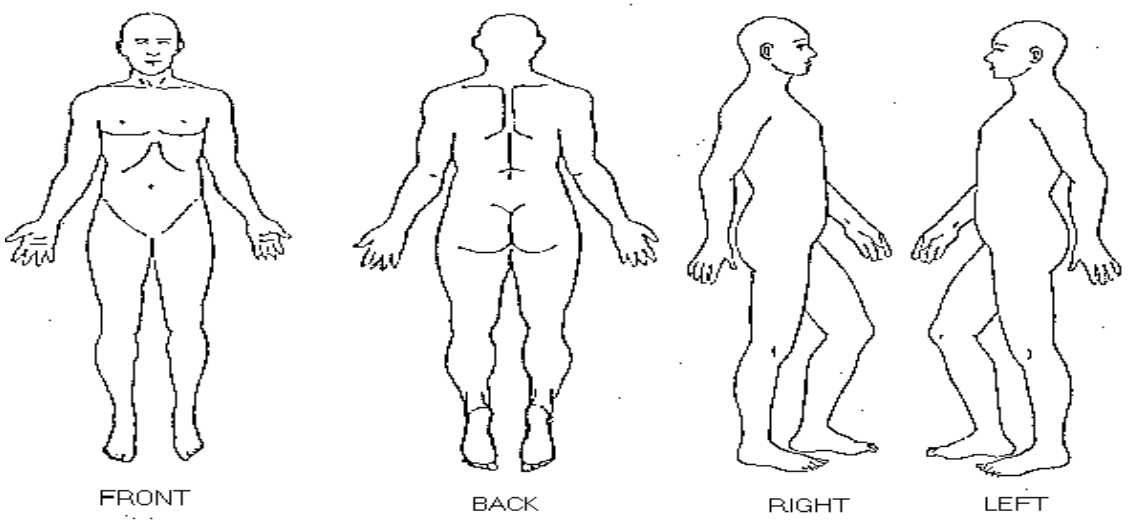
Pain Nature/Duration: Distending Sharp Dull Heavy Colicky Spasmodic

Burning Hollow Fixed Movable Intermittent Constant

Others_____

Please Mark Area of Pain

VAS/Pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (Extreme)



PAST MEDICAL HISTORY:

Cancer _____ Diabetes _____ Hyperlipidemia _____ Hepatitis A, B, or C _____ Heart Disease_____

Hypertension _____ HIV/AIDS _____ Seizures _____Bleeding disorder _____ Substance abuse_____

Thyroid Disease _____

Others: _____

Allergies:_____

Supplements/Herbal Medicine: _____

Medication: (current) :_____

Surgeries/hospitalizations:_____

Family History:

Father: _____ Mother_____ Siblings_____

Habits:

None: _____

Smoking (Yrs.): _____ Alcohol (Yrs.): _____

Coffee: (#cups) _____Tea: (#cups)_____ others: _____

Emotional Status: _____

Women's Questionnaire

Age of first period: _____ Are you currently on the Birth control: Yes No

Pregnancies: Year: _____Vaginal_____ or C section_____

Date of last menstrual cycle: _____ Are you pregnant now: Yes No

Have you experienced menopause: Yes No

If so, when:_____

Menopausal symptoms, please describe: _____

Current menstrual cycle:

Length: _____days

Average number of days/flow: _____

Flow is: Light Normal Heavy

Color: Pale Normal Dark Bright Red Brown

Blood clots: Yes No

Pain or cramping: Yes No

If so, when: Before During After

Do you experience any of the following before your period each month:

Breast tenderness or swelling: Yes No

Mental depression: Yes No

Irritability: Yes No

Other: _____

Men's Questionnaire

Prostate problems: Yes No

Urination problems: _____

Have you ever experienced any of the following: Blood in semen Low Libido Pain or swelling of testicles Discharge Impotence Sexually Transmitted Diseases

Other: _____

Thank you for taking the time to complete the above questions. By answering, you are helping us better serve you.

Do you have any other concerns not mentioned above: _____

_____

_____ / / _____

Patient Signature Date Date