Yellow Dragon Acupuncture, PLLC

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by asking you to take time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask.

Preferred Title: ☐Mr. ☐Mrs. ☐Ms/Miss ☐Dr.				Today's Date:
First Name:		Last Name:		Middle Initial:
Sex/Gender				
Date of Birth:	Age:	Occupation:		
Main phone #		Other contact #		
Email address		Allow email contact by Yellow Dragon? ☐Yes ☐No		
Address: Street:		City:	State:	Zip
Relationship Status	#children	Family Physician		Chiropractor
Do you have health insurance? ☐Yes ☐No		Who is your employer?		
Emergency contact name			Phone	
How did you find out about our clinic? ☐Friend/Relative (name) ______________________________ ☐Direct Mail ☐Location/Walk-by ☐Website ☐Referred by: ________________________ ☐Health Fair/Public Event ☐ 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 kinds of treatment have your tried? ____

What makes the problem worse? ____

What makes the problem better? ____

Is there anybody in your family that with the same/similar problem? __________________________________

Remarks/additional information: ____

Medical History (Please provide the month/year when the event occurred or when diagnosis was established)

Surgeries: ______________________________ **Hospitalizations:** _________________________________

Significant trauma: (auto accidents, sports injuries, etc.) ____

Allergies: (drugs, chemicals, food, environmental) ____

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc. and their dosages):

____

Occupation: ________________________ Do you usually work ☐ indoors ☐ outdoors

Personal Height _________ Weight now _____________ Weight one year ago ___________________

Weight Maximum _____________@ Year _______________

Habits Do you smoke? ☐ Yes ☐ No What? ____________ How many per day? _______ Started: ______

Please describe any use of drugs for non-medical purposes: _____________________________________

Do you exercise regularly? ☐ Yes ☐ No Please describe your exercise program: ___________________

How many hours do you sleep in general? __________ What time do you usually go to bed? ____________

Diet How much coffee do you drink? _______ cups/day Colas _____ number/day Tea ______ cups/day

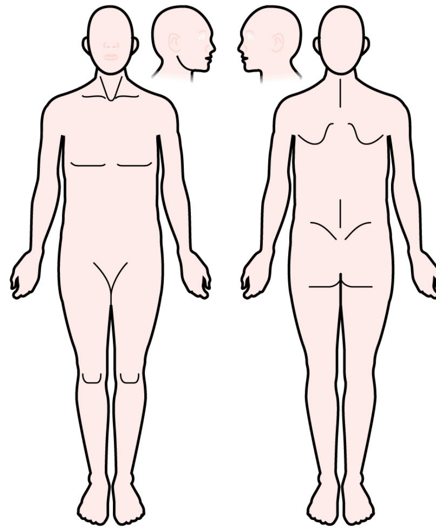
What kind of alcoholic beverages do you usually drink, if any? _________

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) ____

Indicate pain level and/or painful or distressed areas:



Wong-Baker FACES® Pain Rating Scale

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (Type)			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		

Please check if you have had or have (in the last three months) any of the following diseases or conditions.

General ☐Poor appetite ☐ Poor Sleep ☐ Fatigue ☐ Fevers ☐ Chills

☐ Night Sweats ☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Chang in appetite

☐ Poor balance ☐ Bleed or bruise easily ☐Localized weakness ☐ Weight loss ☐ Weight gain

☐ Peculiar tastes ☐ Desire for hot food ☐ Desire for cold food ☐ Strong thirst (cold or hot drinks)

☐ Sudden energy drop (what time of day) ___________ Favorite time of year ___________ Worst time of year __________

Skin & Hair ☐ Rashes ☐ Ulcerations ☐Hives ☐ Itching ☐ Eczema

☐ Pimples ☐ Acne ☐ Dandruff ☐ Dry Skin ☐ Recent mole ☐ Loss of hair

☐ Purpura ☐ Change in hair or skin texture ☐ Other?

Musculoskeletal ☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in 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 and throat ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/contacts

☐ Eye strain ☐ Eye pain ☐Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts

☐ Blurry vision ☐ Earaches ☐ Ringing in the 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 movement: 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

☐ Kidney stones ☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent UTI

☐ Genital pain ☐ Genital itching ☐ Genital rashes ☐ STD ☐ Other?

Reproductive

Sex assigned at birth: ☐ Male ☐ Female Gender reassignment operation(s) ________________________________

☐ Frequent vaginal infections ☐ Pelvic infections ☐Endometriosis ☐ Vaginal/genital discharge

☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods

☐ Breast tenderness ☐ Breast lumps ☐ Infertility problems ☐ Hot flashes ☐ Moodiness related to periods

______ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C- sections _____ Difficult deliveries

Date of last menstrual period ________ Are you currently, or could you be, pregnant? ☐ Yes ☐ No

Age of first menstrual period _____ Duration of periods _____ days Duration of cycle _____ days

Do you practice birth control? ☐ Yes ☐ No If yes, what type and for how long? ________________________________

☐ Prostrate problems ☐ Discharge ☐ Erectile dysfunction ☐ Ejaculation problems

☐ Frequent seminal emissions ☐ 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**