

Office Use Only:
SAMA Candidate? <input type="checkbox"/> Yes <input type="checkbox"/> No

Center for Integrative Medicine Acupuncture Intake Form

Name _____ CLINIC # _____
Last, First Middle

Date of Birth: _____ Gender: M F

Personal Physician: _____ Address: _____

Emergency Contact: _____ Phone: _____

How did you hear about Acupuncture?

Physician: _____ Friend: _____ Pamphlet Seminar Other: _____

Purpose for Visit

Main issue(s), in order of significance to you:

1.	<input type="checkbox"/> Severe	<input type="checkbox"/> Moderate	<input type="checkbox"/> Slight	<input type="checkbox"/> Normal	_____
2.	<input type="checkbox"/> Severe	<input type="checkbox"/> Moderate	<input type="checkbox"/> Slight	<input type="checkbox"/> Normal	_____
3.	<input type="checkbox"/> Severe	<input type="checkbox"/> Moderate	<input type="checkbox"/> Slight	<input type="checkbox"/> Normal	_____
4.	<input type="checkbox"/> Severe	<input type="checkbox"/> Moderate	<input type="checkbox"/> Slight	<input type="checkbox"/> Normal	_____

How do these conditions impair your daily activities? _____

Other treatments you have used: _____

How long have you had these symptoms? _____

What makes your symptoms better? _____ Worse? _____

Have you received a medical diagnosis? Yes No If yes, what is it? _____

Current Medications: _____

Allergies: _____

Please check all that apply: Pregnant Pacemaker Lymphedema Infection of skin; location: _____

Patient Medical History

How was your childhood health? _____

Hospital visits/stays: _____

Immunizations: _____

Surgeries: _____

EMOTIONS & SLEEP:

How do you feel emotionally? _____

Are you: Married/Stable Relationship Single Widowed How do you feel about your relationship? _____

How do you hold your stress? _____

How do you relax? _____

How would you rate your stress level? (0 little or no stress to 10 high stress): _____

How long do you normally sleep? _____ Hours a night Do you feel rested upon waking? _____

Do you have any of the following (please check all those that apply):

√	Overall Temperature (KI Fxn)
<input type="checkbox"/>	Cold Hands
<input type="checkbox"/>	Cold Feet
<input type="checkbox"/>	Sweaty Hands
<input type="checkbox"/>	Sweaty Feet
<input type="checkbox"/>	Hot body temperature (sensation)
<input type="checkbox"/>	Cold body temperature (sensation)
<input type="checkbox"/>	Afternoon flushes
<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	Heat in the hands, feet and chest
<input type="checkbox"/>	Hot flashes any time of the day
<input type="checkbox"/>	Thirsty
<input type="checkbox"/>	Perspire easily
<input type="checkbox"/>	Lack of perspiration
<input type="checkbox"/>	Take water to bed
<input type="checkbox"/>	Difficulty keeping eyes open in the daytime

√	Overall Energy (LU, KI Fxn)
<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Difficulty keeping eyes open in the daytime
<input type="checkbox"/>	General Weakness
<input type="checkbox"/>	Easily catch colds
<input type="checkbox"/>	Feel worse after exercise

√	Blood (LIV, SP, HT Fxn)
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	See floating black spots

√	HT Fxn
<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Sores on the tip of the tongue
<input type="checkbox"/>	Restlessness
<input type="checkbox"/>	Mental confusion
<input type="checkbox"/>	Chest pain traveling to shoulder
<input type="checkbox"/>	Frequent dreams
<input type="checkbox"/>	Wake unrefreshed
<input type="checkbox"/>	Drink coffee (#of cups per day: _____)

√	LU Fxn
<input type="checkbox"/>	Nasal discharge (Color: _____)
<input type="checkbox"/>	Cough
<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	Sinus congestion
<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	Dry throat
<input type="checkbox"/>	Dry nose
<input type="checkbox"/>	Dry skin
<input type="checkbox"/>	Allergies (to what? _____)
<input type="checkbox"/>	Alternating fevers and chills
<input type="checkbox"/>	Sneezing
<input type="checkbox"/>	Headache (location: _____)
<input type="checkbox"/>	Overall achy feeling in the body
<input type="checkbox"/>	Stiff neck
<input type="checkbox"/>	Stiff shoulders
<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	Difficulty breathing
<input type="checkbox"/>	Smoke cigarettes (#per day: _____)
<input type="checkbox"/>	Sadness
<input type="checkbox"/>	Melancholy

√	SP Fxn
<input type="checkbox"/>	Low appetite
<input type="checkbox"/>	Abrupt weight gain
<input type="checkbox"/>	Abrupt weight loss
<input type="checkbox"/>	Abdominal bloating
<input type="checkbox"/>	Abdominal gas
<input type="checkbox"/>	Gurgling noise in the stomach
<input type="checkbox"/>	Fatigue after eating
<input type="checkbox"/>	Prolapsed organs (organ: _____)
<input type="checkbox"/>	Easily bruised
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Pensive/Reflective/Day dreaming
<input type="checkbox"/>	Over thinking
<input type="checkbox"/>	Worry

√	SP, ST, LI, SI Fxn
<input type="checkbox"/>	Loose stool
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Incomplete bowel movements
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	Mucous in stool
<input type="checkbox"/>	Undigested food in stool
<input type="checkbox"/>	General sensation of heaviness in the body
<input type="checkbox"/>	Mental sluggishness
<input type="checkbox"/>	Mental fogginess
<input type="checkbox"/>	Swollen hands
<input type="checkbox"/>	Swollen feet
<input type="checkbox"/>	Swollen joints
<input type="checkbox"/>	Chest congestion
<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Snoring

√	ST Fxn
<input type="checkbox"/>	Burning sensation after eating
<input type="checkbox"/>	Large appetite
<input type="checkbox"/>	Bad breath
<input type="checkbox"/>	Mouth(canker) sores
<input type="checkbox"/>	Bleeding, swollen or painful gums
<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	Acid regurgitation
<input type="checkbox"/>	Ulcer (diagnosed)
<input type="checkbox"/>	Belching
<input type="checkbox"/>	Hiccups
<input type="checkbox"/>	Stomach Pain
<input type="checkbox"/>	Vomiting

√	LIV,GB Fxn
	Alternating loose and hard stool
	Chest pain
	Tight sensation in chest
	Bitter taste in mouth
	Anger easily
	Frustration
	Depression
	Irritability
	Frequent inability to adapt to stress
	Skin rashes
	Headaches at the top of the head
	Tingling sensation
	Numbness
	Muscle Spasms
	Muscle twitching
	Muscle cramping
	Seizures
	Convulsions
	Lump in throat
	Neck tension
	Limited range of motion, neck
	Shoulder tension
	Limited range of motion, shoulder
	Drink alcohol
	Recreational drugs
	High pitched ringing in the ears
	Gall stones
	Sexually transmitted disease

√	Eyes (LIV Fxn)
	Itchy
	Bloodshot
	Hot
	Dry
	Watery
	Gritty
	Blurred vision
	Decreased night vision
	Near-sighted
	Far-sighted

√	Libido
	Normal
	High
	Low

√	KI,UB Fxn
	Frequent cavities
	Easily broken bones
	Sore knees
	Weak knees
	Cold sensation in the knees
	Low back pain
	Poor memory
	Excessive hair loss
	Low-pitched ringing in the ears
	Kidney stones
	Bladder infections
	Frequent night time urination
	Lack of bladder control
	Fear
	Easily startled

√	Urination
	Normal color
	Dark yellow
	Clear
	Reddish
	Cloudy
	Scanty
	Profuse
	Strong odor
	Burning
	Painful
	Difficult
	Urgent
	Frequent

√	Overall Temperature (KI Fxn)
	Cold Hands
	Cold Feet
	Sweaty Hands
	Sweaty Feet
	Hot body temperature (sensation)
	Cold body temperature (sensation)
	Afternoon flushes
	Night sweats
	Heat in the hands, feet and chest

√	Women Only
	Regular cycle? <input type="checkbox"/> Y <input type="checkbox"/> N
	Date of last period: _____
	Infertility? <input type="checkbox"/> Y <input type="checkbox"/> N
	Number of children: _____
	Age of first menstruation: _____
	Average # of days of flow: _____
	Average # of days of cycle: _____
	Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N
	Number of pregnancies: _____
	Number of miscarriages: _____
	Number of abortions: _____
	Age of menopause: _____
	Vaginal discharge: <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Slight <input type="checkbox"/> Normal
	Menstrual bleeding: <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Slight <input type="checkbox"/> Normal <input type="checkbox"/> Clots <input type="checkbox"/> Spotting
	Color of menses: _____
	Irregular menstruation
	Vaginal itching/burning
	Uterine fibroids
	Birth control use; what type: _____
	Do you experience any of the following PMS symptoms:
	<input type="checkbox"/> Nausea
	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Migraines
	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Food cravings
	<input type="checkbox"/> Irritability
	<input type="checkbox"/> Breast swelling
	<input type="checkbox"/> Breast tenderness
	<input type="checkbox"/> Depression
	<input type="checkbox"/> Bloating
	<input type="checkbox"/> Vomiting
	Dull pain, where? _____
	Sharp pain, where? _____
	<input type="checkbox"/> Pain before period
	<input type="checkbox"/> Pain during period
	<input type="checkbox"/> Pain after period

√	Men Only
	Swollen Testes
	Testicular Pain
	Impotence
	Premature Ejaculation
	Feeling of cold or numb in testicles

Women Only

Not Applicable

Please fill in the following menstrual chart:

I no longer have periods

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other:							

PLEASE COMPLETE IF YOU ARE SEEKING TREATMENT FOR PAIN:

No pain

Please describe your pain level (0 no pain at all to 10 being the worst):

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Do any of the following lessen the pain?

Pressure Cold Heat Exercise Other: _____

Do any of the following worsen the pain?

Pressure Cold Heat Exercise Other: _____

Location of pain: _____

How long have you had pain? _____ years _____ months _____ days

How often are you experiencing pain: _____

What makes the pain worse: _____

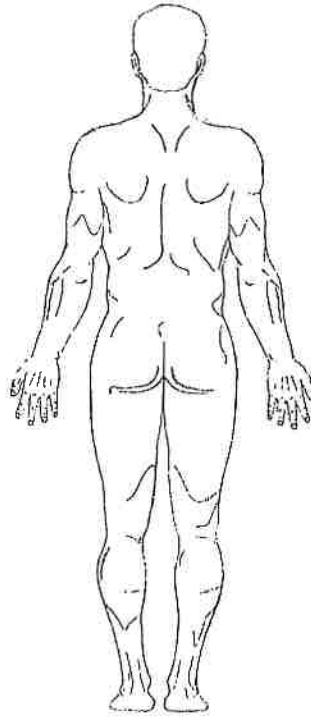
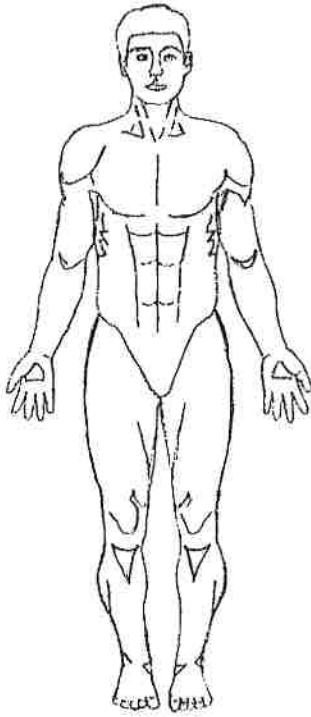
Pain character: Dull Sharp Cramping Burning Radiating Ache Moves Numb Tingling

When did pain begin: _____

Was pain caused by an injury: Yes: _____ No

Prior treatment: Medication Blocks/Injections Surgery PT Chiropractor Massage Other: _____

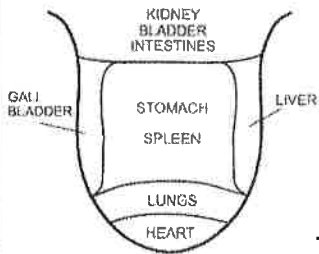
Using the letters at the bottom of the page to describe your pain, indicate directly on the figures the area(s) where you are experiencing pain.



D- Dull	S- Sharp	C – Cramping	B – Burning
R – Radiating	M – Moves About	N – Numbness	T – Tingling
X – Scars from injury or surgery	A – Ache	O – Rashes, Skin Disorders	Other:

****For Acupuncturist Only****

TCM Tongue Dx:



TCM Tongue Characteristics: _____

TCM Pulse Dx:

Left Side

	Cun	Guan	Qi
Floating			
Mid			
Deep			

Right Side

	Cun	Guan	Qi
Floating			
Mid			
Deep			

TCM Pulse Characteristics: _____

Cleveland Clinic Center for Integrative Medicine

Acupuncture Information

Acupuncture is a form of healthcare involving the stimulation of certain points on the body with the insertion of fine needles or the application of heat or friction. The stimulation of these acupuncture points assists the natural healing abilities of the body and helps to restore balance both physically and emotionally. Acupuncture can treat a variety of disorders, but is not a substitute for conventional medical treatment and diagnoses. It is also important to note that because everyone responds to treatment differently, I cannot guarantee the outcome of the treatment.

While most patients do not feel pain with the insertion of needles, they may experience other sensations such as, cramping, deep aching, tingling, and shooting sensations. These are common reactions and not a cause for alarm. However, if the feeling persists or worsens it is important to let the acupuncturist know so the needles can be adjusted or removed to maximize comfort during treatment. It is also important to advise the acupuncturist if you experience any of the following while the needles are in place: dizziness, nausea, cold sweat, shortness of breath, or faintness. These symptoms are associated with an extremely rare condition known as needle shock, which is treated by simply removing the needles. This condition is usually caused by anxiety when receiving acupuncture for the first time. Although the negative side effects of acupuncture are few, it should be advised that local bruising or soreness can occur once the needles are removed.

In order to ensure the best outcome from your acupuncture treatment, please make sure you have eaten something before receiving acupuncture. It is also important that you are not excessively fatigued or emotionally upset. Patients who are under the influence of alcohol or recreational drugs will not be treated. During treatment, while the needles are in place, do not change your position or move suddenly.

I, the undersigned, have read and understand the above statements and have had the opportunity to ask questions regarding my treatment.

Signature of Patient

Date

Signature of Practitioner

Date

For Patient Review Regarding Diagnostic Exam
Please sign one of the two options below:

Option 1:

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

Patient Signature

Date

Option 2:

I have NOT received a diagnostic exam by a physician or a chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or a chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

Patient Signature

Date

Licensed Acupuncturist Signature

Date

CC: Patient file, Copy to Patient