TEXAS ACUPUNCTURE CLINIC

Client Intake Form

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

Full name	Sex F M Date
Date of birth Age	Occupation
Main phone #	Other phone #
E-mail address	Allow email contact by TAC Yes No
Emergency contact name & phone	
Address: Street	City State Zip
Family physician	Chiropractor
Do you have health insurance? Yes No If yes, name of insurance company	
Does your insurance cover acupuncture? Yes No ? Have you ever been treated by acupuncture before?	
Cancellation Policy: 24 hour notification of appointment cancellation is required for all patients. Failure to do so will result in payment in full. Credit card type Mastercard Visa Discovery American Express Credit Card # _____ Expiration Date _____Month _____Year Security Code # _____ Billing zip code _____ Credit cards will automatically be charged if Cancellation Policy is not met.	
How did you find out about our clinic? *Friends/Relatives(name)*_____ *Direct mail* *Location or walk by* *Website* *Referred by*_____ *Yelp* *Austin All Natural Magazine* *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 kind of treatment have you tried? _____

What makes this problem worse? _____What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____ Remarks and additional information:

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
HIV/AIDs			Depression or anxiety			Other:		

Surgeries: _____**Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

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

_____

Occupation: _____ Do you usually work indoors outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal: Height_____ Weight now_____ Weight one year ago_____

Weight maximum _____@Year _____

Habits: Do you smoke ? Yes No What? _____ How many per day? _____ Since when? _____

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? _____ When 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) _____

Please describe your average daily diet (Please be as specific as possible):

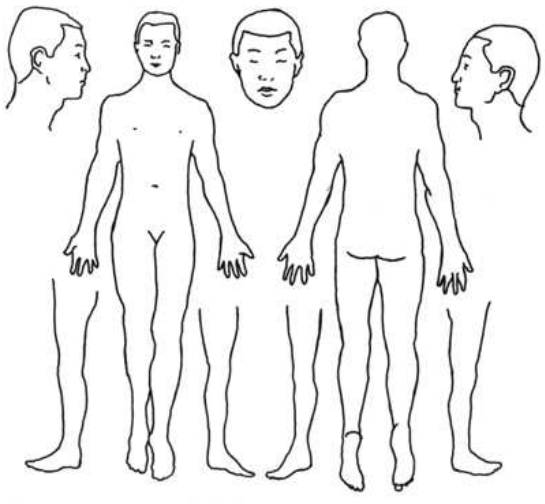
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



Please check if you have or have had (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	Change in appetite	
Poor balance	Bleed or bruise easily	Localized weakness	Weight loss	Weight gain	
Peculiar tastes	Desire hot food	Desire 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 moles	Loss of hair
Purpura	Change in hair or skin texture		Other?		
Musculoskeletal:	Joint disorders	Muscle weakness	Pain/soreness in the 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, & throat:		Dizziness	Concussions	Migraines	Glasses/lens
Eye strain	Eye pain	Color blindness	Night blindness	Poor vision	Cataracts
Blurry vision	Earaches	Ringing in 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 movements: 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 urinary tract infection	
Genital pain	Genital itching	Genital rashes	STD	Other?	
Female:	Frequent vaginal infections	Pelvic infection	Endometriosis	Vaginal/genital discharge	
Fibroids	Ovarian cysts	Irregular periods	Clots	Pain/cramps prior/during periods	
Breast tenderness	Breast Lumps	Fertility Problems	Hot flashes	Moodiness related to periods	
Frequent yeast infections	Excessive facial hair	Low Libido	Bowel movement changes close to periods		
_____ Number of pregnancies	_____ Number of births	_____ Miscarriages	_____ Abortions		
_____ Premature births	_____ C-section	_____ Difficult delivery			

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

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

If you're on birth control pills, what are you taking and for how long? _____

Date of last pap smear _____ / _____ / _____

Male:	Prostate problems	Discharge	Erectile dysfunction	Ejaculation problems
	Frequent seminal emission	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**