WATKINS
ACUPUNCTURE
CLINIC

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Patient/Client Intake Form

Please allow 30-45 minutes to complete most of this questionnaire. Please answer the questions below as thoroughly as possible so that we many make the best possible clinical assessment. This helps me develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you. That said; please answer only the questions you are comfortable answering.

PATIENT/CLIENT CONTACT

Patient/Client Name: _____
Last Name First Name Middle Initial

How would you like to be addressed?/ Preferred Name? _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Gender: _____ Employment Status: _____

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ ext. _____

Cell Phone: _____ Email Address: _____

Preferred Method of Contact: ☐ Call ☐ Text ☐ Email

Preferred Contact Number: ☐ Cell ☐ Home ☐ Work

Occupation: _____

Employer: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone: Home: _____ Cell: _____

PRIMARY CARE PROVIDER*

Name: _____ Phone Number: _____

Address: _____

☐ I do not have a Primary Care Provider

* No contact will be made without your permission.

OTHER MEDICAL SPECIALIST* (Specialist, Counselor/Psychologist, Gynecologist, etc.)

Name: _____ Phone Number: _____

Type of Practitioner: _____

OTHER MEDICAL SPECIALIST* (Specialist, Counselor/Psychologist, Gynecologist, etc.)

Name: _____ Phone Number: _____

Type of Practitioner: _____

* No contact will be made without your permission.

I certify the above information is true and correct to the best of my knowledge.

_____
Printed Name of Legal Guardian (if under 18 years of age)

_____ _____
Signature of Client or Legal Guardian Date

REASON FOR SEEKING CARE-

What is your main reason for coming today?

Are you seeking care for specific health problems, symptoms, or conditions? (Please List)

What, if any, surgeries, operations, or procedures have you undergone, and when?

Have you ever been hospitalized for reasons other than surgeries/operations?
If so, when and for what reason(s)?

PERSONAL & FAMILY HEALTH HISTORY:
Please check box to indicate if you or a biological family member has ever had any of the following conditions. If condition does not apply, leave blank.
For personal health history, indicate P for past conditions or C for current conditions.

Medical Condition	Self	Mother	Father	Sibling(s)	Other family members
Allergies					
Alcohol/Drug Addiction					
Anemia					
Anxiety					
Arthritis					
Cancer					
Cataracts					
Clotting disorder					
Depression					
Diabetes					
Fibromyalgia					
GERD					
Glaucoma					
Heart Disease					
High Cholesterol					
High Blood Pressure					

Medical Condition	Self	Mother	Father	Sibling(s)	Other family members
HIV/AIDS					
Irritable Bowel Syndrome					
Kidney Disease					
Lyme Disease					
Mental Illness (other than anxiety or depression)					
Nerve/Muscle Disease					
Osteoporosis					
Parkinson's/Dementia/Alzheimer's					
PTSD					
Respiratory Disease (e.g., COPD, emphysema)					
Seizures					
Sickle cell anemia					
Stroke					
Thyroid Disease					
Ulcers					
Vision Problems					
Other					

FOR WOMEN:

Number of Pregnancies:
Number of Births:
Number of Children:

Are you currently pregnant?
Are you actively trying to conceive?
Are you currently breastfeeding?

Date of last menstrual period:

How long is your cycle:

How long between cycles:

Do you have any issues with moody changes, pain/cramps, or other menstrual concerns:

Do you utilize contraception? Yes / No If yes, what type(s)?

HEALTH-RELATED BEHAVIORS

DIET

In general how healthy is your overall diet ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Are you satisfied with your diet? Yes / No

SLEEP

At what time are you typically in bed?

What time do you fall asleep?

Do you have difficulty falling asleep?

Do you have difficulty staying asleep?

Typical total hours asleep?

Number of times you awaken during the night?

Do you feel rested upon rising?

PHYSICAL ACTIVITY

How would you categorize your activity level? Sedentary Mildly Active Moderately Active Very Active

How many days per week do you exercise?

What types of exercise do you do?

What is the general intensity when you exercise?

STRESS

On a scale of 1 - 10 with 1 being low and 10 being high, how stressful is your:

Work: _____ Social/Family: _____ Current Health: _____ Life in General: _____

What do you do to cope with stress?

Do you feel that your current state of health is:

Largely in your control or Largely out of your control

LIFESTYLE

What are your hobbies and interests?

How do you typically spend your day?

With whom do you live? (Include roommates, spouse, children, relatives, pets, etc.)

	Frequency					Comments
	Never	Less than once/month	Monthly	Weekly	Daily	
Social Activity						
Relaxation						
Spiritual/Religious practice						
Mindfulness Practices						
Alcohol						
Tabacco						
Recreational Drugs						
Sexual Activity						

Significant Life Events:

Please list any major events of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, job changes, miscarriages, illness, and anything else you feel greatly impacted your life.

Date **Event**

MEDICATIONS/SUPPLEMENTS

Please list any mediations you are taking currently or take on a regular basis (including over the counter medications).

Name	Dosage	Frequency	Reason for Taking	Prescribing Provider	Start Date

Please list any herb, vitamin, or supplement products you are taking currently or take on a regular basis. Please include brand names. If your product has a number of ingredients it can be helpful to bring it with you to your visit.

Name	Dosage	Frequency	Reason for Taking	Start Date

HEALTH ASSESSMENT / SYMPTOM QUESTIONNAIRE

Point Scale:
0 = Never or almost never have the symptom.
1 = Occasionally have it; effect is not severe.
2 = Occasionally have it; effect is severe.
3 = Frequently have it; effect is not severe.
4 = Frequently have it; effect is severe.

Medical Symptom Questionnaire
Use this questionnaire to chart your health and progress. Rate each of the following symptoms based on your health for the past thirty days.

Digestive Tract
_____Nausea or vomiting
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching or passing gas
_____Heartburn
_____**Total**

Ears
_____Itchy ears
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears, hearing loss
_____**Total**

Emotions
_____Mood swings
_____Anxiety, fear, or nervousness
_____Anger, irritability or aggressiveness
_____**Total**

Energy/Activity
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness
_____**Total**

Eyes
_____Watery or itchy eyes
_____Swollen, reddened, or sticky eyelids
_____Bags or dark circles under eyes
_____Blurred or tunnel vision
_____Slurred speech
_____**Total**

Mouth/Throat
_____Chronic coughing
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen or discolored tongue, gums, lips
_____Canker sores
_____**Total**

Head
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia
_____**Total**

Heart
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest Pain
_____**Total**

Joints/Muscles
_____Pain or aches in joints
_____Arthritis
_____Stiffness or limitation in movement
_____Pain or aches in muscles
_____Feeling of weakness or tiredness
_____**Total**

Lungs
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____**Total**

Mind
_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Difficulty in making decisions
_____Stuttering or stammering
_____Learning disabilities
_____**Total**

Skin
_____Acne
_____Hives, rashes, or dry skin
_____Hair loss
_____Flushing or hot flashes
_____Excessive sweating
_____**Total**

Nose
_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation
_____**Total**

Other
_____Frequent illness
_____Genital itch or discharge
_____**Total**

Weight
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Underweight
_____Water retention
_____**Total**

_____**Grand Total**

Is there anything else that you would like me to know?

	YES	NO
If you frequently get up at night do you notice what time? (if yes, what time?)		
Are you troubled by frightening dreams or thoughts?		
Do you experience leakage of urine?		
Do you have any difficulty starting your urine flow?		
Do you have a constant feeling that you have to urinate?		
Do you have difficulty hearing?		
Do you have problems with your teeth?		
Have you ever had seizures or convulsions?		
Has your handwriting changed lately?		
Do you have a tendency to shake or tremble?		
Do you have trouble making decisions?		
Would you say you have a hopeless outlook?		
Have you ever considered committing suicide?		
Do you ever see “floaters” before your eyes? (little floating specs or string-like things)		
Are you getting cramps in your legs at night or upon walking?		
Do you ever faint or feel faint?		
Is your tongue sore or sensitive?		
Do you ever get pains or tightness in your chest?		
Do you have trouble with dizziness or lightheadedness?		
Have you ever been told that you have a heart murmur?		
Do you suffer from manic episodes?		
Have you been diagnosed with ADD or ADHD (Circle which one.)		
Do you have trouble stopping even a small cut from bleeding?		
Do you bruise easily?		
Have you lost your interest in eating lately?		
Do you alway seem to be hungry?		
Do you suffer discomfort in the pit of your stomach?		
Do you experience pain in your stomach or abdomen after eating?		
Do you experience bloating on a regular basis?		
Have you ever coughed up blood?		
Do you have trouble with swollen feet or ankles?		
Does your skin itch or burn?		

Are you having any sexual difficulties?		
Are your bowel movements ever loose for more than one day?		
Are you bowel movements ever black or bloody?		
Do you suffer pains when you move your bowels?		
Have you had any bleeding from your rectum?		
Does your nose ever bleed for no apparent reason?		
Are you bothered by coughing spells?		
Are you sweating more than usual or having night sweats?		
Does any part of your body always feel numb?		
Do you find it hard to concentrate or remember?		
Are you thirsty more than usual?		
Is it difficult or painful for you to swallow?		
GENDER SPECIFIC QUESTIONS	YES	NO
Has a doctor ever told you that you have prostate trouble?		
Have you had any burning or discharge from your penis?		
Are there any swellings or lumps on your testicles?		
Is your urine stream weak or slow?		
Do your testicles get painful?		
Are you past menopause or have you had a hysterectomy?		
If yes, have you noticed any vaginal bleeding since?		
Have you ever noticed any lumps or pain in your breasts?		
Have you had complications with any type of birth control?		
Have you ever had an abortion?		
Have you had gender reassignment surgery?		
Were there any complications?		

If you feel that any important piece of information or symptoms were not covered above, please note them here:

_____

_____

Your Signature: _____ Date:_____