



acupuncturekitchen

Acupuncture Kitchen Intake Form For Naturopathic Medicine

Name _____ Today's date _____

Date of birth _____ Age _____ Sex: Male Female Blood Type _____

Context of Care

Why did you choose to come to this clinic, and what do you know about our approach? _____

Health Concerns

Please list your main health concerns in order of importance.

1. Describe your condition _____

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe:* _____

2. Describe your condition _____

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe:* _____

3. Describe your condition _____

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe:* _____

4. Describe your condition _____

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe:* _____

What would you most like to accomplish on your **first visit**? _____

What long-term expectations do you have from working with us? _____

Healthcare History and Providers Information

Who is your primary care physician? _____

When was your last physical exam? (Month/year) _____

Blood work / Lab work (Month/year) _____

Who is your dentist? _____
 (Name) (Address/ Phone)

When was your last dental visit? (Month/year) _____

Who is your optometrist? _____
 (Name) (Address/Phone)

When was your vision last checked? (Month/year) _____

Are you currently under the care of or seeing a specialist? *Please provide Name, Address and Phone*

1: _____

2: _____

3: _____

Have you had any of the following in the last ten years?

Test	When For what reason?	Result Outcome
Bone Density (DEXA)		
CT scan		
Colonoscopy		
EKG		
Endoscopy		
MRI		
Ultrasound		
X-ray		

Are you currently under the care of an alternative healthcare provider (i.e.: Acupuncturist, chiropractor, massage therapist)?

Please provide Name, Address and Phone

1: _____

2: _____

Past Medical History

List any medical conditions you have experienced (*i.e.: Diabetes, Cancer, Epilepsy, High Blood Pressure*)

Procedure	Year

Hospitalizations / Surgeries (including Tonsils, Gallbladder, Appendix, Cosmetic)

Procedure	Year

Major Injuries

Accident/Injury	Year

Vaccinations

Have you received your childhood vaccinations? Yes No

If yes, which did you receive?

- Polio Rubella Flu Vaccine Tetanus Measles Diphtheria
 Smallpox Mumps Hepatitis B Pertussis Other: _____

Have you received the vaccination for chicken pox? Yes No

Do you receive the yearly flu vaccination? Yes No

Have you received Gardasil®/HPV vaccination? Yes No

Have you received any vaccinations for travel? Yes No

If yes, which vaccinations _____

Allergies

Please list all known allergies to medications, supplements, food, environmental, vaccinations, etc:

Medications / Supplements

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications	Reason	Date began	Dose	Effective? (yes/no)

Have you ever been treated with or used any of the following? (check all that apply)

- Antibiotics more than 2 weeks Antibiotics more than 2 times/year Antacids
 Antihistamines Blood thinners Diabetes medications
 Diuretics Hormonal therapy Laxatives/stool softener
 Sleeping pills Steroids Stimulants Thyroid medication

Supplements	Reason	Date began	Dose	Effective? (yes/no)

Where do you purchase your supplements?

- Health food store Supplement store Club/Grocery store Internet Other _____

Family History

Relative	Age if living	Age if deceased	Relative	Age if living	Age if deceased
Mother			Maternal Grandmother		
Father			Maternal Grandfather		
Siblings			Paternal Grandmother		
			Paternal Grandfather		

Have your relative(s) ever had any of the following? *M = mother's side OR F = Father's side*

Condition	M side	F side	Which Family Member(s) / Date
Alcoholism			
Allergies			
Alzheimer's			
Anemia			
Asthma			
Arthritis			
Bleeding disorders			
Cancer ()			
Cancer ()			
Celiac			
Crohns			
Depression			
Diabetes Type 1			
Diabetes Type 2			
Down's Syndrome			
Eczema			
Epilepsy			

Gall Bladder Disease			
Genetic Disorder			
Gout			
Heart Disease			
Condition	M side	F side	Which Family Member(s) / Date
Hemorrhoids			
High Blood Pressure			
High Cholesterol			
Lupus			
Mental Illness			
Migraine Headaches			
Obesity			
Osteoporosis			
Stroke before age 50			
Stroke after age 50			
Thyroid (hypo/hyper)			
Other _____			
Other _____			
Other _____			
Other _____			

Lifestyle

Relationship: Single Married Partnership Separated Divorced Widowed If Married/Partnership how long have you been together? _____

Live with: Spouse Partner Parents Children Friends Alone

Are you sexually active? Yes No If yes, with (check one): Male Female Both

Do you or your partner(s) use contraception? Yes No If so, what type(s)? _____

Are you pregnant? Yes No

Trying to get pregnant? Yes No If yes, for how long? _____

Do you have children? Yes No

How many? _____

Names and ages of your children? _____

Personal

What is your height? _____

	Current	Last year	5 years ago	Ideal
Weight in lbs				

Have you ever been a smoker? No Yes Yes, in past

If yes, how many packs per day? _____ How long have you smoked? _____

Are you exposed to secondhand smoke? Yes No If yes, from where? _____

How often do you drink alcohol and how much at one time? _____

Do you use recreational drugs? Yes No How often? _____

How often do you exercise? _____ What kind of exercise do you do? _____

How much time do you spend outdoors per week? _____

What do you do to relax? _____

Describe your supportive network _____

Do you have a spiritual routine / practice? _____

What behaviors or habits do you engage in regularly to support your health? _____

What behaviors or habits do you engage in regularly that are destructive to your health? _____

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health? _____

What is your occupation? _____

Do you like your job? Yes No

How many hours a week do you work? _____

To what extent are you open to changes in lifestyle to address your health concerns?

I am willing to consider changes

I am willing to make some changes

I will do whatever it takes

How many hours a night do you sleep? _____

What time do you go to bed? _____ What time do you rise in the morning? _____

Do you wake refreshed? Yes No

Do you have trouble falling asleep? Yes No If yes, what keeps you up? _____

Do you have trouble staying asleep? Yes No If yes, how many times a night do you wake up and is there a consistent time that you wake up throughout the night? _____

Diet

How many meals do you eat daily? _____

How much water do you drink daily? _____ What type of water do you drink? _____

How many sodas, coffees or teas with caffeine do you drink per week? _____

How many times per week do you eat dairy products? _____

How many times per week do you eat red meat? _____

How many times per week do you eat fish? _____

How many times per day do you eat fruit? _____

How many times per day do you eat vegetables? _____

Are there organic foods in your diet? Yes No

How often do you eat out? _____ /week

What foods do you crave? _____

Do you have dietary restrictions? Yes No

If yes, describe _____

Are you satisfied with your current diet? Yes No

If no, describe _____

Environmental Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home, at work or when traveling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced health problems after putting down new carpets, painting, doing renovations or having your lawn sprayed with herbicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sensitive to perfume, gasoline or other vapors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever lived near a refinery or high pollution area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever lived in a home more than 50 years old?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have mercury dental fillings? How many? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any dental root canal procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any surgical implants? (Medical or Cosmetic)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you live near power lines?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Review of Systems

Y = Yes for present symptoms or have had in past 3 months

P = Past symptoms. It is possible to check both "Y" and "P".

General	
Chills	<input type="checkbox"/> Y <input type="checkbox"/> P
Fever	<input type="checkbox"/> Y <input type="checkbox"/> P
Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> P
Frequent Colds	<input type="checkbox"/> Y <input type="checkbox"/> P
Night Sweats	<input type="checkbox"/> Y <input type="checkbox"/> P
Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> P

Skin	
Acne	<input type="checkbox"/> Y <input type="checkbox"/> P
Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> P
Eczema	<input type="checkbox"/> Y <input type="checkbox"/> P
Itching	<input type="checkbox"/> Y <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> P
Mole color change	<input type="checkbox"/> Y <input type="checkbox"/> P
Rashes	<input type="checkbox"/> Y <input type="checkbox"/> P

Neurological	
Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of balance	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of memory	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Numbness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tingling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vertigo / Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Head	
Headaches	<input type="checkbox"/> Y <input type="checkbox"/> P
Injury	<input type="checkbox"/> Y <input type="checkbox"/> P
Migraines	<input type="checkbox"/> Y <input type="checkbox"/> P

Eyes / Ears / Nose / Throat	
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> P
Dryness	<input type="checkbox"/> Y <input type="checkbox"/> P
Eye pain	<input type="checkbox"/> Y <input type="checkbox"/> P
Glasses /Contacts	<input type="checkbox"/> Y <input type="checkbox"/> P
Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> P
Tearing	<input type="checkbox"/> Y <input type="checkbox"/> P
Vision problems	<input type="checkbox"/> Y <input type="checkbox"/> P
Ear discharge	<input type="checkbox"/> Y <input type="checkbox"/> P
Ear pain	<input type="checkbox"/> Y <input type="checkbox"/> P
Impaired hearing	<input type="checkbox"/> Y <input type="checkbox"/> P
Ringling	<input type="checkbox"/> Y <input type="checkbox"/> P
Hay fever	<input type="checkbox"/> Y <input type="checkbox"/> P
Nosebleeds	<input type="checkbox"/> Y <input type="checkbox"/> P
Post nasal drip	<input type="checkbox"/> Y <input type="checkbox"/> P
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> P
Stiffness	<input type="checkbox"/> Y <input type="checkbox"/> P
Canker sores	<input type="checkbox"/> Y <input type="checkbox"/> P
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> P
Goiter	<input type="checkbox"/> Y <input type="checkbox"/> P
Gum problems	<input type="checkbox"/> Y <input type="checkbox"/> P
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> P
Jaw clicking /pain	<input type="checkbox"/> Y <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> P
Neck pain /Stiffness	<input type="checkbox"/> Y <input type="checkbox"/> P
Sore tongue	<input type="checkbox"/> Y <input type="checkbox"/> P
Swollen glands	<input type="checkbox"/> Y <input type="checkbox"/> P
Teeth problems	<input type="checkbox"/> Y <input type="checkbox"/> P

Respiratory	
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> P
Cough	<input type="checkbox"/> Y <input type="checkbox"/> P
Chronic cough	<input type="checkbox"/> Y <input type="checkbox"/> P
Difficult breathing	<input type="checkbox"/> Y <input type="checkbox"/> P
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> P
Pain on breathing	<input type="checkbox"/> Y <input type="checkbox"/> P
Positive TB test	<input type="checkbox"/> Y <input type="checkbox"/> P
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> P
At night	<input type="checkbox"/> Y <input type="checkbox"/> P
On exertion	<input type="checkbox"/> Y <input type="checkbox"/> P
Lying down	<input type="checkbox"/> Y <input type="checkbox"/> P
Spitting up blood	<input type="checkbox"/> Y <input type="checkbox"/> P
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> P

Cardiovascular	
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> P
Blood clots	<input type="checkbox"/> Y <input type="checkbox"/> P
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> P
Cold hands	<input type="checkbox"/> Y <input type="checkbox"/> P
Cold feet	<input type="checkbox"/> Y <input type="checkbox"/> P
Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> P
Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> P
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> P
Low blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> P
Leg cramps	<input type="checkbox"/> Y <input type="checkbox"/> P
Murmur	<input type="checkbox"/> Y <input type="checkbox"/> P
Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> P
Poor circulation	<input type="checkbox"/> Y <input type="checkbox"/> P
Swelling of feet	<input type="checkbox"/> Y <input type="checkbox"/> P
Varicose vein	<input type="checkbox"/> Y <input type="checkbox"/> P

Gastrointestinal	
Belching / Gas	<input type="checkbox"/> Y <input type="checkbox"/> P
Bloating	<input type="checkbox"/> Y <input type="checkbox"/> P P
Change in thirst	<input type="checkbox"/> Y <input type="checkbox"/> P
Constipation	<input type="checkbox"/> Y <input type="checkbox"/> P
Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> P
Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> P
Itching around rectum	<input type="checkbox"/> Y <input type="checkbox"/> P
Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> P
Nausea	<input type="checkbox"/> Y <input type="checkbox"/> P
Trouble swallowing	<input type="checkbox"/> Y <input type="checkbox"/> P
Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> P
Undigested food in stool	<input type="checkbox"/> Y <input type="checkbox"/> P
Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> P
Gallbladder Disease	<input type="checkbox"/> Y <input type="checkbox"/> P
Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> P
How many bowel movements per day? _____	
Is this a change? <input type="checkbox"/> Y <input type="checkbox"/> N	
Have you ever traveled to a third world country? If so, for how long? _____	

Musculoskeletal	
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> P
Broken bones	<input type="checkbox"/> Y <input type="checkbox"/> P
Joint pain	<input type="checkbox"/> Y <input type="checkbox"/> P
Joint stiffness	<input type="checkbox"/> Y <input type="checkbox"/> P
Muscle cramps	<input type="checkbox"/> Y <input type="checkbox"/> P
Muscle spasms	<input type="checkbox"/> Y <input type="checkbox"/> P
Sciatica	<input type="checkbox"/> Y <input type="checkbox"/> P
Weakness	<input type="checkbox"/> Y <input type="checkbox"/> P

Immune	
Cold sores	<input type="checkbox"/> Y <input type="checkbox"/> P
Chronic infections	<input type="checkbox"/> Y <input type="checkbox"/> P
Frequent antibiotics	<input type="checkbox"/> Y <input type="checkbox"/> P
Frequent colds/	<input type="checkbox"/> Y <input type="checkbox"/> P

Endocrine	
Do you awake feeling rested?	<input type="checkbox"/> Y <input type="checkbox"/> P
Generally feel cold	<input type="checkbox"/> Y <input type="checkbox"/> P
Generally feel hot	<input type="checkbox"/> Y <input type="checkbox"/> P
Low blood sugar	<input type="checkbox"/> Y <input type="checkbox"/> P
Mental sluggishness	<input type="checkbox"/> Y <input type="checkbox"/> P
Recently lost or gained weight	<input type="checkbox"/> Y <input type="checkbox"/> P
25 pounds change in weight	<input type="checkbox"/> Y <input type="checkbox"/> P
Sluggish after eating	<input type="checkbox"/> Y <input type="checkbox"/> P
flus	
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> P
Mononucleosis	<input type="checkbox"/> Y <input type="checkbox"/> P
Shingles	<input type="checkbox"/> Y <input type="checkbox"/> P
Slow wound healing	<input type="checkbox"/> Y <input type="checkbox"/> P
Swollen glands or lymph nodes	<input type="checkbox"/> Y <input type="checkbox"/> P
Has there ever been an event or sickness that you have never fully recovered from? <input type="checkbox"/> Y <input type="checkbox"/> N Explain. _____	

Mental / Emotional	
Abuse	<input type="checkbox"/> Y <input type="checkbox"/> P
Anxiety / nervousness	<input type="checkbox"/> Y <input type="checkbox"/> P
Depression	<input type="checkbox"/> Y <input type="checkbox"/> P
Mental illness	<input type="checkbox"/> Y <input type="checkbox"/> P
Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> P
Panic attacks	<input type="checkbox"/> Y <input type="checkbox"/> P
Phobias	<input type="checkbox"/> Y <input type="checkbox"/> P
Prolonged sadness or grief	<input type="checkbox"/> Y <input type="checkbox"/> P
What was the most stressful event in your life? _____ _____	
It is still affecting you? <input type="checkbox"/> Y <input type="checkbox"/> N	

Urinary	
Awaken to urinate	<input type="checkbox"/> Y <input type="checkbox"/> P
Frequent infections	<input type="checkbox"/> Y <input type="checkbox"/> P
Increased frequency	<input type="checkbox"/> Y <input type="checkbox"/> P
Inability to hold urine	<input type="checkbox"/> Y <input type="checkbox"/> P
Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> P
Pain on urination	<input type="checkbox"/> Y <input type="checkbox"/> P
Strain to urinate	<input type="checkbox"/> Y <input type="checkbox"/> P

Rate your energy level between 1 and 10
(1=extreme fatigue, 10=most energetic) _____

Rate your stress level between 1 and 10 (1 = less stress, 10 = extremely stressed) _____

At what time of the day is your energy the best? _____
the worst? _____