# *Pathways Acupuncture*
## *Intake Form*

***Personal Information***

Patient Name:_____

Age:_____ Birth Date:____/____/____ Gender: MALE or FEMALE

Address:_____

City:_____State:_____Zip: _____

Telephone:_____

Email Address:_____

Status: Single Married Divorced Separated Widowed

Occupation: _____

Referral Source: _____

Who is your primary health care provider/MD? _____

Emergency Contact: _____Phone:_____

***Responsible Party***

Name of Responsible Party: _____Relationship: _____

Address: _____City: _____State: _____Zip: _____

Telephone: _____Email: _____

**AUTHORIZATION TO RELEASE PATIENT INFORMATION & AUTHORIZATION TO PAY**

**I hereby authorize Pathways Acupuncture Center to release any personal health information (PHI) required in the course of my treatment to the above stated insurance company, or their affiliates and I hereby authorize insurance payment directly to Pathways Acupuncture, for medical services rendered.**

**I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.**

Signed (Patient or guardian) _____Date_____

***Main Reason for seeking Acupuncture***

Please identify your major health concerns

1. _____

   _____

   How long have you had this problem? _____

2. _____

   _____

   How long have you had this problem? _____

3. _____

   _____

   How long have you had this problem? _____

- Have you been given a diagnosis for these problems? _____
- What other treatments have you tried and what were the outcomes? _____

   _____

**ARE YOU CURENTLY TAKING ANY BLOOD THINNERS? NO YES**
**PLEASE LIST THEM ALL**

| | |
|---|---|
| Illnesses | |
| Surgeries | |
| Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.) | |
| Do have a history of current or past infectious disease? Please describe | |
| Medicines (please list all medications, herbs, vitamins and over the counter drugs) | |
| Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to) | |

***Personal Medical History*** *(Please include your childhood history)*

***General*** (please check all that apply)

- ❑ Poor Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Other:
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Tremors
- ❑ Weight Loss
- ❑ Weight Gain

***Skin & Hair***

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

***Head, Eyes, Ears, Nose, and Throat***

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Strain/Pain
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Recurrent Sore Throat
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Headaches
- ❑ Night Blindness
- ❑ Facial Pain
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Blurry Vision
- ❑ Sinus Problems
- ❑ Concussions
- ❑ Poor Hearing
- ❑ TMJ Pain
- ❑ Spots in Front of Eyes
- ❑ Floaters

***Cardiovascular***

- ❑ High Blood Pressure
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Lightheadedness

***Respiratory***

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

***Gastro-Intestinal***

- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching

***Urology***

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Frequent Night Urination

***Neuro-Psychological***

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings

***Gynecology***

- _____ Age of Menses
- _____ Duration of Menses
- _____ Date of Last Menses
- _____ # of Pregnancies
- _____ # of Births
- ❑ Irregular Periods
- ❑ Painful Periods
- ❑ Breast Lumps
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems

***Musculo-Skeletal***

- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Pain with Weather Changes
- ❑ Muscle Weakness
- ❑ Scoliosis
- ❑ Pain with Activity
- ❑ Muscle Cramping
- ❑ Weak Joints
- ❑ Pain After Waking