Physical Medicine & Rehabilitation

THE POLYCLINIC

ACUPUNCTURE INITIAL VISIT INTAKE FORM

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Name: _____ **Referred by**: _____ **MRN**: _____

Date of birth: _____ **Today's Date**: _____

Chief complaint: _____

ONSET: How, when and where did this condition begin — *if MVA, please list exact date of accident*:

_____

_____

Current symptoms:

My symptoms are: Constant or comes and goes? (circle one)

Types of treatments tried:

☐ Physical Therapy. Helpful?	☐ Yes	☐ No	☐ Somewhat
☐ Chiropractic care. Helpful?	☐ Yes	☐ No	☐ Somewhat
☐ Epidural/spinal injections. Helpful?	☐ Yes	☐ No	☐ Somewhat
☐ Muscle relaxers. Helpful?	☐ Yes	☐ No	☐ Somewhat
☐ NSAIDS. Helpful?	☐ Yes	☐ No	☐ Somewhat
☐ Gabapentin. Helpful?	☐ Yes	☐ No	☐ Somewhat
☐ Massage. Helpful?	☐ Yes	☐ No	☐ Somewhat
☐ Heat/cold. Helpful?	☐ Yes	☐ No	☐ Somewhat
☐ Other: _____ Helpful?	☐ Yes	☐ No	☐ Somewhat

What is your pain level at its **worst** on the one to ten scale?

1 2 3 4 5 6 7 8 9 10

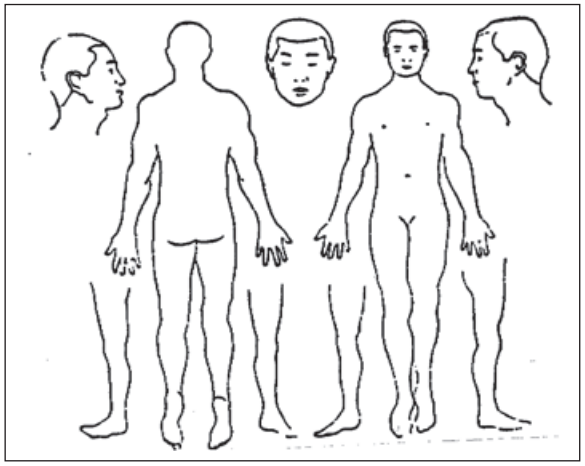
What is your pain level at its **least** on the one to ten scale?

1 2 3 4 5 6 7 8 9 10

Key:

Stabbing ////
Burning XXX
Numbness ====
Pins and needles OOOO
Aching/throbbing ^^^^

Please mark all areas of pain on the diagram:
Where is your pain? How does it feel? Draw your pain using the following key. *Do not indicate areas of pain that are not related to your present injury/condition.*



Physical Medicine & Rehabilitation

Your problem/pain is (check one)	Better	Worse	No Different
When coughing or sneezing			
When you wake up in the a.m.			
Mid-day			
Evening			
In the middle of the night			
Lying on your side			
Lying on your back			
Lying on your stomach			
When you urinate or move your bowels			
Sitting			
Rising from sitting			
Standing			
Walking			
Leaning forward			
Bending forward			
Extending Backwards			
Looking up			

Does your pain/symptom cause depression or anxiety? ☐ Yes ☐ No

Does your pain impact:

a) Employment? ☐ Yes ☐ No **b)** Social activity ☐ Yes ☐ No **c)** Daily activity? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled If yes, full time? ☐ Yes ☐ No

If no, date last worked: _____ On disability? ☐ Yes ☐ No If so, how long? _____

Is your pain related to: ☐ Motor vehicle accident If yes, date of accident: _____

☐ Work-related injury If yes, date of injury: _____

Lifestyle:

How good do you feel your nutrition is? Great / Good / Fair / Poor

Typical Breakfast: _____

Lunch: _____ Dinner: _____ Snacks: _____

Worst food in your diet? _____

What foods do you crave? _____

Water intake per day (in ounces) _____ Caffeine(how much): _____

Do you use tobacco? ☐ Yes ☐ No If yes, how much? _____

Alcohol? ☐ Yes ☐ No If yes, how much? _____

Excercise:

Do you excercise? ☐ Yes ☐ No Number of times per week: _____ Types of excercise: _____

Sleep:

Do you have trouble falling asleep? ☐ Yes ☐ No Time to bed: _____ Time to rise: _____

Hours of sleep/night? ____ Feel rested in a.m.? ☐ Yes ☐ No

Do you wake in the night? ☐ Yes ☐ No

Stressors occurring at this time: _____

Please Also Complete Body System Review on Page 4

Menstruation and Pregnancy:

- Are you currently pregnant? ☐ Yes ☐ No
- Are you using contraception? ☐ Yes ☐ No If yes how long? _____
- Number of pregnancies: _____
- Number of terminations: _____
- Number of miscarriages: _____
- Number of deliveries: _____
- Complications? _____ Dates: _____
- Age of first period: _____
- Was it (light / moderate / heavy)?
- Last menstrual cycle?(Date) _____
- How many day(s) did it last ____ day(s)
- Flow was (light / normal / heavy)?
- Color being (Normal / Red / Pink / Pale)?
- Any blood clots? ☐ Yes ☐ No
- Menstrual cycles are (regular / irregular) spaced?
- Do you experience (cramping / pain)? (before / during / after) period?
- Do you experience (nausea / vomiting)? (before / during / after) period?
- Do you experience bleeding or spotting between periods? ☐ Yes ☐ No
- Do you experience (water retention / breast tenderness or swelling / mental depression / irritability / migraines / food cravings)?
- Do you experience loose bowel movements? ☐ Yes ☐ No
- Do you experience vaginal discharge between periods? ☐ Yes ☐ No

Body Systems Review

Please check if you experience the following:

SPLEEN SYSTEM

- ☐ Low appetite
- ☐ Abdominal distension after eating
- ☐ Weakness of limbs
- ☐ Loose stools
- ☐ Crave sweet foods
- ☐ Prolonged exposure to damp environment
- ☐ History of eating excessive raw food diet
- ☐ Bruise easily
- ☐ Organ prolapsed (diagnosed)
- ☐ Fatigue after eating
- ☐ Abdominal gas/bloating after eating
- ☐ Tend to gain weight easily

LUNG SYSTEM

- ☐ Spontaneous sweating
- ☐ Allergies
- ☐ Asthma
- ☐ General weakness
- ☐ Dry nose/mouth/skin/throat
- ☐ Feel worse after exercise
- ☐ Catch colds easily
- ☐ Shortness of breath
- ☐ Cough
- ☐ Nasal discharge
- ☐ Sinus congestion

LIVER/GALLBLADDER SYSTEM

- ☐ Muscle spasms/twitches
- ☐ Feel better after exercise
- ☐ Tight feeling in chest
- ☐ Alternating diarrhea/constipation
- ☐ Symptoms worse with stress
- ☐ Neck/shoulder tension
- ☐ See floaters in eyes
- ☐ Depression
- ☐ Irritable
- ☐ Nausea
- ☐ Numb extremities
- ☐ Anger easily
- ☐ Red or dry eyes
- ☐ Frequent headaches
- ☐ Sour or metallic taste in mouth
- ☐ Nightmares/disturbing dreams
- ☐ Frequent sighing
- ☐ Alternating constipation and diarrhea

KIDNEY and URINARY BLADDER SYSTEM

- ☐ Sore, cold or weak knees
- ☐ Low back pain
- ☐ Frequent urination
- ☐ Early morning diarrhea
- ☐ Impaired memory
- ☐ Low libido
- ☐ Excessive libido
- ☐ Cold feeling (when others not cold)
- ☐ Cold hands &/or feet
- ☐ Urinary incontinence or dribbling
- ☐ Hearing loss
- ☐ Ankle edema
- ☐ Hair loss
- ☐ Crave salty foods
- ☐ Fatigue/low energy
- ☐ Ear ringing/tinnitus

HEART SYSTEM

- ☐ Heart palpitations
- ☐ Spontaneous sweating
- ☐ Anxiety
- ☐ Insomnia
- ☐ Restlessness
- ☐ Easily startled
- ☐ Pale complexion
- ☐ Sore tip of tongue
- ☐ Poor memory

STOMACH SYSTEM

- ☐ Bad breath
- ☐ Acid reflux (GERD)
- ☐ Swollen or bleeding gums
- ☐ Excessive hunger
- ☐ History of eating excessive fried foods

MISCELLANEOUS

- ☐ Foggy thinking
- ☐ Heat in palms or soles
- ☐ Dizzy upon standing
- ☐ Feeling of heaviness
- ☐ Afternoon fever
- ☐ Night sweats
- ☐ Enlarged lymph nodes
- ☐ Cloudy urine
- ☐ Face flushes

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Signature: _____ Date: _____