Initial Intake Form

Aaron Annis, Licensed Acupuncturist, Massage Therapist, and Chinese Herbalist

Thank you for taking the time to complete the following information, which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

General Information

Name _____

Birthdate: _____/ _____/ _____ Birth Time (as stated on birth certificate) _____ (AM / PM)

Age _____ Gender _____ Marital Status: Single Married Other

Number of Children _____ Age(s) _____

Address _____ City _____ State _____ Zip _____

Cell Phone (____) _____ Home Phone (____) _____ Work Phone (____) _____

Email _____

Your education level _____ Occupation _____ Hrs./Week_____

Employer & Location _____

Job Title _____

We now offer phone and email reminders, please select which method you prefer: Cell Home Email

Please let us know how you found out about our clinic: _____

Emergency Contact

Name _____ Phone (____) _____ Relationship _____

Name _____ Phone (____) _____ Relationship _____

Legal Guardian (Minors only)

Healthcare Providers (Please list all with whom you work with)

GP/ Primary Care:		Psychotherapist:	
OB-GYN:		Personal Trainer:	
Chiropractor:		Midwife:	
Massage Therapist:		Specialist (Describe):	
Physical Therapist:		Other:	

Are you seeking any of these types of healthcare providers? ☐ Y ☐ N
May I contact these providers to ensure coordination of your care? ☐ Y ☐ N
Do you have previous experience with acupuncture? ☐ Y ☐ N

Health History
Please list you major health concerns in order of importance to you:

_____

_____

Check all those apply to your past medical history:

☐ Alcoholism
☐ Allergies
☐ Arthritis & Rheumatism
☐ Asthma
☐ Attempted Suicide
☐ Birth Trauma
☐ Bleeding Disorder
☐ Blood Disease
☐ Cancer or Tumors
☐ Diabetes
☐ Emphysema
☐ Eating Disorder
☐ Fibromyalgia
☐ Heart Disease
☐ Hepatitis / Liver Disease
☐ Herpes
☐ High Blood Pressure
☐ HIV / AIDS
☐ Immune Disorder
☐ Joint Replacement
☐ Kidney Disorder
☐ Low Blood Pressure
☐ Lyme's Disease
☐ Lymph Nodes Removed
☐ Mental Illness
☐ Multiple Sclerosis
☐ Pacemaker
☐ Polio
☐ Rheumatic Arthritis
☐ Rheumatic Fever
☐ Sciatica
☐ Scarlet Fever
☐ Seizures/ Epilepsy
☐ Sinus Infections
☐ Skin Disease
☐ Special Diet
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease / STD
☐ Other:

List any serious diseases, injuries, surgeries, or hospitalizations that you have had and the month / year they occurred:

Date ____ / _____ Event _____ Date ____ / _____ Event _____
Date ____ / _____ Event _____ Date ____ / _____ Event _____
Date ____ / _____ Event _____ Date ____ / _____ Event _____

Please indicate approximate dates, and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, death, bankruptcy, etc.):

Date ____ / _____ Event _____ Date ____ / _____ Event _____
Date ____ / _____ Event _____ Date ____ / _____ Event _____
Date ____ / _____ Event _____ Date ____ / _____ Event _____

Family History (List any family physical or mental illnesses and age of death):

Mother:	Siblings:
Father:	Children:
Grandparents:	

Medications, herbs, and supplements (list those you are currently taking, why, and for how long):

_____
_____
_____
_____
_____

Lifestyle Habits (describe your daily diet):

Breakfast:	Lunch:
Dinner:	Snacks:
Special Diet:	3 most unhealthy foods you eat:

Do you:	Yes	No	What is the main source of joy in your life?
Average 6-8 hours of sleep?			
Have a supportive relationship?			
Have a history of abuse?			What is the main source of stress in your life?
Enjoy your work?			
Take vacations?			
Spend time outside?			

Exercise?			Describe:
Watch TV?			Hours weekly?
Read books?			Hours weekly?
Play computer games?			Hours weekly?
Browse the internet?			Hours weekly?
Have spiritual/ religious practices?			Describe:
Smoke cigarettes?			How much?
History of cigarette smoking?			How many years? Packs per day?
Eat out often?			How many meals per week?
Drink coffee?			Cups per day?
Drink tea?			Cups per day?
Drink soda?			How many per day?
Use sugar?			How much?
Drink alcohol?			Drinks per week?
Use recreational drugs?			Describe:
Have an addiction?			Describe:
Travel outside of the U.S.?			Where?

What are your goals for your health?

_____

_____

_____

_____

Please circle your level of commitment to correcting your health issues (10 = highest):

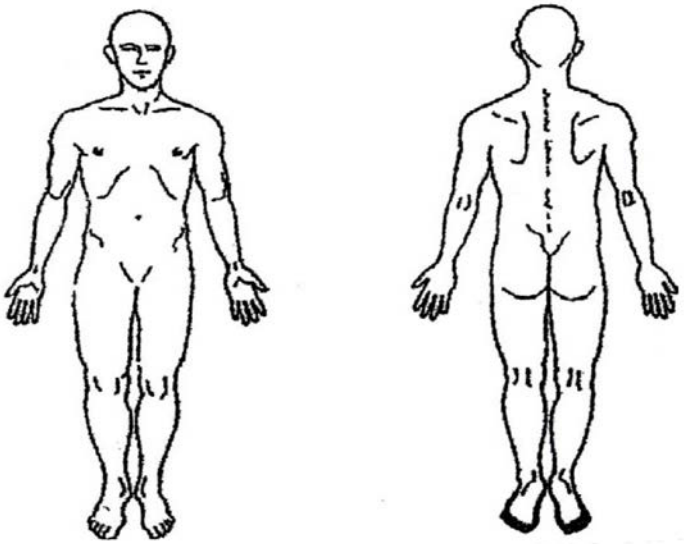
1 2 3 4 5 6 7 8 9 10

Tests and Immunizations

Please list the date of your most recent visit:

Chest X-ray:	Sigmoidoscopy:	EKG:
Mammogram:	TB skin test:	Pap Smear:
GI series:	Flu shot:	Pneumonia shot:
Stool blood test:	Complete physical:	Other:

Patient Pain Profile Please clearly mark any areas of pain and any scars (please indicate which areas are scars)



Is the pain:

☐ Sharp	☐ Burning	☐ Aching
☐ Cramping	☐ Dull	☐ Throbbing
☐ Fixed	☐ Moving	

Do the following decrease the pain?

☐ Pressure	☐ Cold
☐ Exercise	☐ Heat

Do the following increase the pain?

☐ Pressure	☐ Cold
☐ Exercise	☐ Heat

Oswestry report filled out?

☐ Yes

Please mark the appropriate squares in the following list of symptoms.
If you have had the symptom in the PAST and do not currently have it now, mark the box like this: ■
If you CURRENTLY experiencing the symptom mark the box like this: ■

	Lung / Large Intestine
☐	Bloody Cough
☐	Dry Cough
☐	Chronic Cough
☐	Cough with Sputum
☐	Nasal Discharge
	☐ Clear ☐ White ☐ Yellow ☐ Green
☐	Post-Nasal Drip
☐	Sinus Infection / Congestion
☐	Itchy / Red / Painful Throat
☐	Skin Rashes / Hives
☐	Snoring
☐	Shortness of Breath
☐	Asthma / Allergies
	To What:
☐	Low Immunity
☐	Catch Colds Easily
☐	Bronchitis
☐	Black or Bloody Stools
☐	Constipation
☐	IBS
☐	Diarrhea
☐	Colitis / Spastic Colon
☐	Crave Pungent or Spicy Foods
☐	Grief / Sadness

	Kidney / Urinary Bladder
☐	Urinary Problems (i.e. night-time)
☐	Bladder Infection
☐	Incontinence
☐	Weakness / Low Back Pain (not associated with trauma)
☐	Osteoporosis
☐	Feel Cold or Hot Easily
☐	Low or Excess Sex Drive (circle which)
☐	Dark Circles Under Eyes
☐	Thyroid Problems
	Describe:
☐	Poor Memory
☐	Hair Loss / Grey hair
☐	Hearing Problems / Tinnitus
☐	Frequent Cavities
☐	Hot Flashes / Night Sweats
☐	Impotence or Premature Ejaculation (circle which)
☐	Kidney Stones
☐	Waking More Than Twice a Night to Urinate
☐	Frequent Urination
☐	Burning/ Painful / Difficult Urination (circle which)
☐	Discharge with Urination
☐	Cloudy Urine
☐	Crave Salty Foods
☐	Feeling Frightened or Fearful

	Liver / Gallbladder
	Depression / Stress / Anxiety
	Headaches / Migraines
	Red / Dry / Itchy eyes
	Visual Problems / Blurred Vision
	Dizziness
	Gall Stones
	Feeling of Lump in Throat
	Clenching Teeth at Night
	Muscle Cramping / Twitching
	Neck / Shoulder Pain or Tightness
	Seizures / Tremors
	Poor Circulation (esp. of the hands and feet)
	Soft / Brittle Nails or Hair
	PMS / Menstrual Problems / Hot flashes
	Tingling Sensation
	Numbness
	Tendonitis
	Pain Below Rib Cage
	Sour Food Craving
	Tendency to be Irritable / Angry / Frustrated
	Alternating Fever / Chills
	Alternating Diarrhea / Constipation
	Tight Sensation in the Chest
	Frequent Sighing
	Frequent Need to Stretch
	Dry Lips
	Frequently Unable to Adapt to Stress
	Causes:

	Overall Temperature
	Cold Hands / Feet (circle which)
	Sweaty Hands / Feet (circle which)
	Sensation of Hot / Cold Body Temperature
	Afternoon Flushes
	Night Sweats
	Heath in the Hands/ Feet/ Chest
	Hot Flashes any Time of Day
	Perspire Easily
	Lack of Perspiration

	Heart / Small Intestine
	Heart Palpitations
	Rapid or Irregular Heartbeat
	Chest Pain
	High Blood Pressure
	Low Blood Pressure
	Insomnia / Sleep Problems
	Vivid Dreams / Nightmares
	Easily Startled
	Dark or Reddish Urine
	Red Complexion
	Bitter Food Craving
	Anxiety / Nervousness / Restlessness
	Drink Caffeine?
	How Many Cups Per Week:
	Spleen / Stomach
	Body Heaviness
	Difficulty Getting up in the Morning
	Muscles Often Feel Tired
	Edema: ☐ Hands ☐ Feet
	Easily Bruising / Bleeding
	Bad Breath
	Sweet-ish Taste in Mouth
	Lack of Taste
	Excess or Low Appetite (circle which)
	Excess or Lack of Thirst (circle which)
	Nausea / Vomiting
	Gas / Belching / Hiccoughs
	Hemorrhoids
	Organ Prolapse (i.e. uterus)
	Chronic Loose Stools
	Abdominal / Stomach Pain
	Indigestion / Heartburn
	Bleeding/ Swollen / Painful Gums
	Acid Reflux
	Ulcer (diagnosed)
	Foggy Brain
	Mouth Ulcers
	Tendency to Gain Weight
	Sweet Food Craving
	Over-Thinking / Worry
	Abdominal Bloating

Female Only

Regular Menstrual Cycle? Y ☐ N ☐ Pregnant? Y ☐ N ☐

Vaginal Discharge is: ☐ Severe ☐ Moderate ☐ Slight ☐ Normal
Bleeding Between Periods: ☐ Severe ☐ Moderate ☐ Slight ☐ Normal

Number of Children: Number of Pregnancies:
Age of First Menstruation: Age of Menopause (if applicable)
Average Number Days of Flow: Average Number Days of Entire Cycle:

Do you experience any of the following pre-menstrual symptoms?

☐ Nausea ☐ Food Cravings ☐ Depression ☐ Vomiting
☐ Headaches ☐ Irritability ☐ Water Retention ☐ Migraines
☐ Anxiety ☐ Breast Swelling ☐ Breast Tenderness

☐ Sharp Pain? Where? ☐ Dull Pain? Where?

☐ Other Emotions:

☐ Other:

Do you experience or have you ever experienced any of the following in part?

☐ UTIs ☐ Endometriosis ☐ Vaginal Sores
☐ Fertility Problems ☐ Ovarian Cysts ☐ Vaginal Dryness
☐ Fibroids

Menstrual Chart (Please indicate severity on a scale of 0-3)

	Day1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale brown, rust, dark, purple)							
Amount of flow (0= normal 3=heavy)							
Pain / Cramps (location?)							
Clots (large, small, black, purple, red, other)							
Nausea / Vomiting (check if yes)							

Male Only

Please check all that apply and the severity:

☐ Swollen Testes ☐ Severe ☐ Moderate ☐ Slight ☐ Normal
☐ Testicular Pain ☐ Severe ☐ Moderate ☐ Slight ☐ Normal
☐ Impotence ☐ Severe ☐ Moderate ☐ Slight ☐ Normal
☐ Premature Ejaculation ☐ Severe ☐ Moderate ☐ Slight ☐ Normal
☐ Cold or Numbness in External Genitals ☐ Severe ☐ Moderate ☐ Slight ☐ Normal
☐ Other:

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunctions or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunctions or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Blyss Acupuncture as soon as possible.*

Acupressure / Oriental Massage: I understand that I may also be given acupressure/oriental massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read, and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Patient Name (Please Print): _____

Signature: _____Date: _____

SIGN BELOW ONLY IF YOU REQUESTED TO RECEIVE MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

Signature: _____ Date: _____

Explained and signed in my presence: _____ Date: _____