

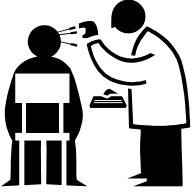
Acupuncture Health Services

86-15A 65th Dr.

Rego Park, NY 11374

718-459-1036

Rosemarie A. Caligiuri, L.Ac.



Patient Intake Form

Welcome to our office! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **COMMENTS** section. Thank you!

Date: ____/____/____ **How did you here about us?** _____

Name: _____

Street: _____ City _____ State _____ Zip _____

Age: _____ Height: _____ Weight: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security No. _____

Occupation: _____ Marital Status: _____

In Emergency Notify: _____

Primary Physician: _____

Address: _____ Telephone No. _____

Email Address: _____

Have you tried Acupuncture or Herbal medicine before? _____

MAIN COMPLAINT that brings you here today: _____

Has your complaint been evaluated by a doctor? _____

What diagnosis have you received? _____

What medications are you currently using? _____

For which conditions? _____

When was your last Physical Examination? _____

Any significant injuries, major illnesses and/or surgeries whether hospitalized or not? _____

How does this problem affect your daily activities? (work, sleep, eating, etc) _____

How long has it been since you first noticed any symptoms? _____

What kinds of treatment or therapy have you tried? _____

Has any of these therapies improved the condition? _____

PAST MEDICAL HISTORY:

<input type="checkbox"/> AIDS/HIV _____	<input type="checkbox"/> Drug Abuse _____	<input type="checkbox"/> Polio _____
<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Emphysema _____	<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Scarlet Fever _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Hepatitis A/B/C _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Birth Trauma _____ (your own birth) _____	<input type="checkbox"/> Herpes _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Lyme Disease _____	<input type="checkbox"/> Latex Allergy _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Multiple Sclerosis _____	<input type="checkbox"/> Lymph Nodes Removed _____
	<input type="checkbox"/> Pace Maker _____	<input type="checkbox"/> Other _____

Vaccinations: _____

Childhood Illnesses: _____

DIET & FOOD

How is your appetite? _____

Do you crave any foods? _____

Any food intolerances? _____

Any food allergies? _____

List any vitamins and supplements you are taking: _____

Describe a typical meal for: Breakfast: _____

Lunch: _____

Dinner: _____

How often do you have: Meat: _____ Day/Week Coffee/Tea (caffeinated): _____ Day/Week

Sugar/Sweets: _____ Day/Week Dairy (milk, cheese, yogurt): _____ Day/Week

Are you always thirsty? Yes No Do you prefer Hot or Cold drinks?

How many cups/glasses do you drink daily? ____ Water, ____ Soda, ____ Coffee/Tea, ____ Alcohol: Day/Week

Rate your taste preferences 5 to 1 (5=like most, 1=dislike most) ____ Salty ____ Sour ____ Bitter ____ Sweet
____ Spicy**GASTROINTESTINAL**I have (Check ALL that apply) Belching Nausea Vomiting Vomiting Blood Ulcers Bloating Acid Regurgitation Heartburn Hernia Indigestion Severe Stomach Pain Other _____Bowel Movements: How often? _____ Day/Week Painful Bowel Movements? Yes NoI have (Check ALL that apply): Irregular Bowel Movements Constipation Diarrhea Gas Burning Hemorrhoids Use Laxatives Undigested food in stools Loose Stools Hard Stool Blood in Stool Itchiness Irritable Bowel Syndrome Colitis Crohn's Disease Other _____**EXERCISE & ENERGY**

How is your energy? _____

What time of day is your energy: Highest? _____ Lowest? _____

Do you fatigue easily? _____

What type of exercise do you do? _____

How often do you exercise? _____

STRESS & SLEEP

Do you have: Panic Attacks Depression Anxiety Bad Temper Nervousness

Fear Attacks Poor Memory Difficulty Concentration Other _____

How do you feel about your relationship? _____

Married/Stable Relationship Single

How do you hold stress? _____

How do you feel about your work? _____

Do you use: Anti-Depressants Sleeping Pills Other _____

How many hours do you sleep? _____

Do you have difficulty with: Falling Asleep Staying Asleep Disturbed Sleep

Waking up at about _____ am/pm and not being able to fall asleep again because _____

URINARY & GENITAL

Urination: How often? _____ times per day Color: Pale Yellow Dark Yellow/Orange

I have or have had (Check ALL that apply): Trouble Starting Stream Frequent Urination,

Incontinence Pain Trouble Holding Urine Burning Dribbling when Sneezing

Urinary Tract Infections Blood in Urine Kidney Stones Other _____

How is your sexual energy? _____

What kind of birth control do you use? _____

Do you have (Check ALL that apply): Infertility Pain during intercourse Other _____

WOMEN

At what age did you start menstruating? _____ Number of days between cycles? _____

Number of days of flow: _____ Color: _____

I have or had (Check ALL that apply): Irregular Menstruation Heavy Flow Light Flow

No Flow Clots Vaginal Burning Vaginal Itching Spotting between Periods

Discomfort/Pain before period Discomfort/Pain during period Discomfort/Pain after period

Other _____

Any vaginal discharge? Yes No Amount _____ Color _____ Frequency _____

PMS Symptoms: _____

Number of Pregnancies? _____ Number of Deliveries? _____ Number of Live Births? _____

Menopausal Symptoms? _____

MEN

I have (Check ALL that apply): Prostatitis Impotence Penis Discharge (blood/mucous)

Other _____

CARDIOVASCULAR

Blood Pressure _____/_____ Have you been diagnosed with heart trouble? Yes No

I have (Check ALL that apply): Chest Pain Palpitations Varicose Veins Phlebitis

Cold hands & Feet Irregular Heart Beat Poor Circulation Other _____

RESPIRATORY, EYES, EARS, NOSE, THROAT & HEAD

Do you smoke? Yes No _____ per day for _____ years

I have (Check ALL that apply): Frequent Colds Chronic Runny Nose Chronic Cough
 Coughing Blood Pain Inhaling Shortness of Breath on Exertion/at Rest Asthma
 Nose Bleeds Pain/Red Eyes Poor Vision See Spots/Floaters Dizziness Cold Sores
 Bleeding Gums Dry Mouth Frequent Sore Throat Ear Pain Ringing in the Ears
 Clogged/Popping Ears Coughing Mucous How Much? _____ Color _____
 Frequent Headaches Migraines Other _____

SKIN & HAIR

I have (Check ALL that apply): Dry Skin Skin Rashes Itching Acne Eczema Hives Pimples
 Ulcerations Recent Moles Herpes Simplex Herpes Zoster Warts Rosacea Ringworm Dandruff
 Dry Hair Hair Loss Premature Graying Greasy/Oily Hair Dry Scalp Redness/Pain of Scalp
 Other _____

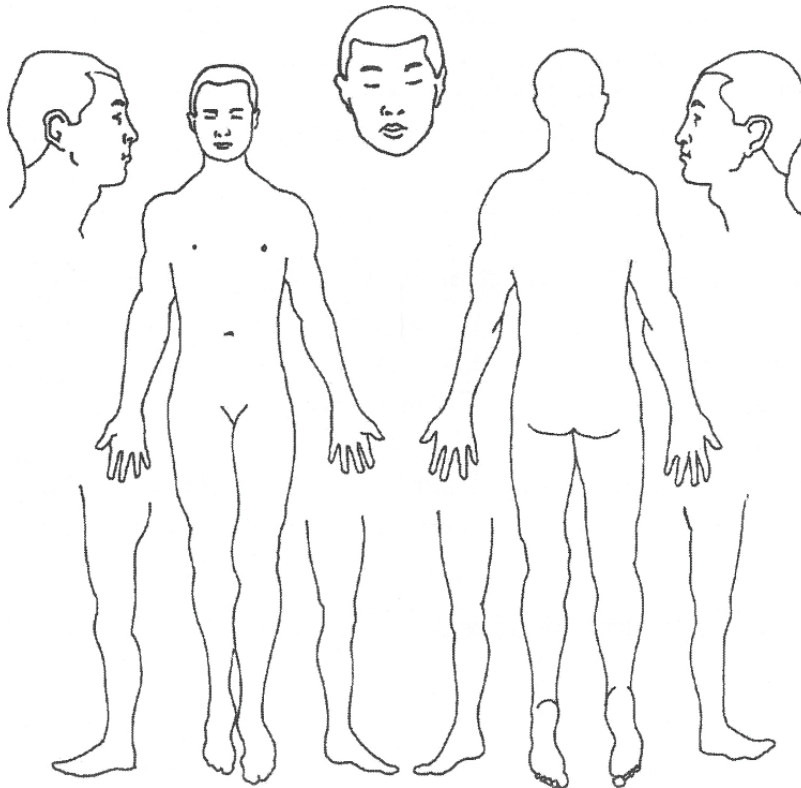
EMOTIONAL/MENTAL/PSYCHOLOGICAL INFORMATION

Have you ever been treated for emotional problems? _____

MUSCULO-SKELETAL:

Please mark or shade the area where your pain is located:

- Head Pain
- Shoulder Pain
- Elbow Pain
- Wrist Pain
- Hand Pain
- Neck Pain
- Upper Back Pain
- Middle Back Pain



- Knee Pain
- Ankle Pain
- Foot Pain
- Muscle Spasms/Weakness
- Muscle Pain
- Lower Back Pain
- Hip Pain

Do you have pain or tightness? Where? _____

The pain is (Check ALL that apply): Sharp Aching Numb Deep Pain Burning Tingling
 Dull Superficial Pain Pain Better/Worse with Heat Pain Better/Worse with Cold
 Pain Better/Worse with Pressure Pain Better in am/pm Pain Worse in am/pm

I have (Check ALL that apply): Swollen Joints Arthritis/Joint Pain Tendonitis _____
 Muscle Pain Rheumatism Bone Pain Muscle Cramping Repetitive Strain Injury Other _____