Lauren Barbrey, L. Ac.

Initial Intake

This is a CONFIDENTIAL record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization.

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Email Address _____

Referred by _____ Blood Type _____

Birth Date _____ Age _____ Sex: M F Height _____ Weight _____

Marital Status ž Married ž Single ž Divorced ž Widowed Number of children _____

Have you received acupuncture therapy before? ž Yes ž No

When? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	ž	ž	_____	Diabetes	ž	ž	_____
Hepatitis	ž	ž	_____	Heart Disease	ž	ž	_____
High Blood Pressure	ž	ž	_____	Seizures	ž	ž	_____
Rheumatic Fever	ž	ž	_____	Emotional Disorder	ž	ž	_____
Infectious Diseases	ž	ž	_____	Tuberculosis	ž	ž	_____

Sexually transmitted diseases: ž Gonorrhea ž Syphilis ž AIDS ž HPV ž Herpes Date _____

List any medications and supplements you are currently taking: (Continue on back if necessary.)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last Checkup

Lauren Barbrey, L. Ac.

Initial Intake

What are the main health problems for which you are seeking treatment?

_____
_____
_____
_____

When did you first notice this problem? Have you had it in the past?

_____
_____

What makes it better? What makes it worse?

_____
_____

What other forms of treatment have you sought?

_____
_____
_____

List any other health problems you now have.

_____
_____
_____

List any allergies, food sensitivities or food cravings that you have.

_____
_____

When was your last physical exam by your doctor?

_____

Please indicate the use and frequency of the following:

	Yes	No	How much		Yes	No	How much		Yes	No	How much
Coffee	ž	ž	_____	Tobacco	ž	ž	_____	Water Intake	ž	ž	_____
Non-medical drugs	ž	ž	_____	Alcohol	ž	ž	_____	Soda Pop	ž	ž	_____

Do you eat wheat? Yes/No Do you eat dairy? Yes/No Are you vegetarian? Yes/No

How many hours do you sleep per night? ____ Do you have trouble falling asleep? ____ Staying asleep? ____

How often do you have a bowel movement? _____ Do you have a tendency towards diarrhea? Y/N Constipation? Y/N

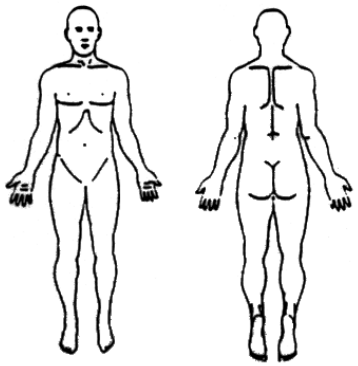
Lauren Barbrey, L. Ac.

Initial Intake

List any accidents, surgeries, or hospitalizations (include date).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please mark any areas of pain.



Women:

Age of first menstruation _____ Date of last menstrual period _____
Number of days of flow _____ Number of days between periods _____
Clots? _____ PMS? (describe) _____
Are you pregnant? ž Yes ž No Number of pregnancies _____ Births _____
Date of last: Gyn/Pap Smear _____ Pap Results _____
Do you take hormones? If so, what kind _____
Other pertinent information _____
Other symptoms related to menses:

ž Discharge	ž Vaginal Dryness	ž Headache
ž Nausea	ž Constipation	ž Diarrhea
ž Swollen Breasts	ž Mood Swings	ž Ravenous appetite
ž Poor appetite	ž Hot Flashes	ž Night sweats
ž Increased libido	ž Decreased libido	ž Insomnia

Men:

Date of last prostate check up _____ PSA results _____ Hernia? _____
Frequency of urination: daytime _____ nighttime _____ Difficult or burning urination? _____
Other pertinent information _____
Symptoms related to prostate:

ž Prostate problems	ž Delayed stream	ž Dribbling	ž Incontinence
ž Rectal dysfunction	ž Increased libido	ž Decreased libido	ž Premature Ejaculation
ž Impotence	ž Back Pain	ž Groin Pain	ž Other _____

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not experience. Please indicate by:

( ) no mark = never experience (√) = sometimes (+) = frequently experience

___ lack of appetite
___ excessive appetite
___ loose stool or diarrhea
___ indigestion
___ vomiting
___ belching
___ heartburn
___ feeling of retention of food in the stomach
___ easily bruised
___ insomnia, difficulty sleeping
___ heart palpitations
___ cold hands/feet
___ nightmares
___ mentally restless
___ chest pain
___ cough
___ shortness of breath
___ decrease sense of smell
___ nasal problems
___ skin problems
___ bronchitis
___ colitis
___ asthma
___ constipation
___ hemorrhoids
___ antibiotic use
___ low back pain
___ knee problems
___ hearing impairment
___ ear ringing
___ kidney stones
___ decreased sex drive
___ hair loss
___ eye problems
___ jaundice
___ hepatitis
___ soft/brittle nails
___ easily angered
___ difficulty making decisions
___ depression
___ dizziness
___ fainting
___ high blood pressure
___ high cholesterol
___ sudden weight gain
___ sudden weight loss
___ abdominal pain
___ sciatic pain
___ headaches