Clear Skies Healing – Patient Intake Form

Name _____ Date _____
Home Address_____
City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell Phone_____
Occupation _____ Person responsible for your account _____
Email Address: _____
Sex: ☐ Male ☐ Female Height _____ Weight _____ Birth date _____ Age _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of children _____

Have you ever received acupuncture before? ☐ Yes ☐ No
Have you ever taken Chinese herbs before? ☐ Yes ☐ No
When and with whom? _____

What are the main problems for which you are seeking treatment?
_____
_____
_____
What other treatments have you sought? _____

List any other health problems you have right now: _____
_____

List any allergies, food sensitivities, or cravings: _____
_____

List and **medications, herbs, or supplements** you are taking, including dosage and reason you are taking them:_____
_____
_____

List any accidents, surgeries, or recent hospitalizations: _____
_____
_____

Lab results: _____
_____

Please indicate if you or a relative have or have had the following illnesses and the approximate **date(s)**:

	You	Relative	Date		You	Relative	Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tuberculosis	☐	☐	_____

STDs: Gonorrhea ☐ Chlamydia ☐ AIDS/HIV ☐ HPV ☐ Herpes ☐ Other ☐_____ Date: _____

For Women

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No # of pregnancies _____

Age of last period (menopause) _____ # of live births _____ # of abortions _____ # of miscarriages _____

Number of days between periods _____ Date of last: GYN Exam _____ Pap Smear _____

Number of days of flow _____ Mammogram _____ Bone Density Scan _____

Color of flow _____ Results _____

Clots? ☐ Yes ☐ No Color _____ _____

Average number of pads you use per day: 1st day _____ 2nd _____ 3rd _____ 4th _____ + days _____

Location of pain: ☐ Lower abdomen ☐ Lower Back ☐ Thighs ☐ Other _____

Nature of Pain (please indicate before, during or after menses)

Cramping _____ Stabbing _____

Burning _____ Aching _____

Dull _____ Bloating _____

Consistent _____ Intermittent _____

Bearing down sensation _____

Other symptoms related to menses

☐ Discharge ☐ Vaginal dryness ☐ Headache

☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Swollen Breasts ☐ Mood swings ☐ Ravenous appetite

☐ Poor appetite ☐ Hot flashes ☐ Night sweats

☐ Increased libido ☐ Decreased libido ☐ Insomnia

Have you ever been diagnosed with:

☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID Other _____

For Everyone

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

No mark ( ) = never experience **Check mark (√) =** sometimes experience **plus sign (+) =** frequently experience

___ lack of appetite
___ excessive appetite
___ loose stool or diarrhea
___ digestive problems, indigestion
___ vomiting
___ belching, burping
___ heartburn/reflux
___ feeling the retention of food in the stomach
___ tendency to become obsessive in work, relationships
_____
___ insomnia, difficulty sleeping
___ heart palpitations
___ cold hands and feet
___ nightmares
___ mentally restless
___ laughing for no apparent reason
___ angina pains
___ abdominal pain
___ chest pain
___ sciatic pain
___ headaches
___ pain or coldness in the genital area
_____
___ cough
___ shortness of breath
___ decreased sense of smell
___ nasal problems
___ skin problems
___ feeling of claustrophobia
___ bronchitis
___ colitis or diverticulitits
___ constipation
___ hemorrhoids
___ recent use of antibiotics
___ eye problems
___ jaundice (Yellowish eyes or skin)
___ difficulty digesting oily foods
___ gall stones
___ light colored stool
___ soft brittle nails
___ easily angered or agitated
___ difficulty in making plans or decisions
___ spasms or twitching of muscles
_____
___ low back pain
___ knee problems
___ hearing impairment
___ ear ringing
___ kidney stones
___ decreased sex drive
___ hair loss
___ urinary problems
___ fatigue
___ edema
___ blood in stool
___ black tarry stools
___ easily bruised
___ difficult to stop bleeding
___ asthma
___ tendency to catch colds easily
___ intolerance to weather changes
___ allergies
___ hay fever
___ dizziness
___ tendency to faint easily
___ high cholesterol levels
___ sudden weight loss

Please indicate use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Alcohol	☐	☐	_____	Coffee/Black Tea	☐	☐	_____
Tobacco	☐	☐	_____	Soda Pop	☐	☐	_____
Marijuana	☐	☐	_____	Water	☐	☐	_____
Non-medical drugs	☐	☐	_____	Exercise	☐	☐	_____

How do you feel about the following areas of your life?

	Great	**Good**	**Fair**	**Poor**	**Bad**	**Your Comments**
Significant other	⌟	⌟	⌟	⌟	⌟	_____
Family	⌟	⌟	⌟	⌟	⌟	_____
Diet	⌟	⌟	⌟	⌟	⌟	_____
Sex	⌟	⌟	⌟	⌟	⌟	_____
Self	⌟	⌟	⌟	⌟	⌟	_____
Work	⌟	⌟	⌟	⌟	⌟	_____
Exercise	⌟	⌟	⌟	⌟	⌟	_____
Spirituality	⌟	⌟	⌟	⌟	⌟	_____

I certify that the health and medical information I have listed here is complete and accurate to the best of my knowledge.

_____

Patient Name

_____

Patient Signature and Date (or patient representative, indicate relationship if signing for patient)