

**ACUPUNCTURE and CRANIOSACRAL THERAPY INTAKE**

Name\_\_\_\_\_Date\_\_\_\_\_

Address\_\_\_\_\_City\_\_\_\_\_Zip\_\_\_\_\_

Home phone\_\_\_\_\_Work phone\_\_\_\_\_Cell phone\_\_\_\_\_

Email address\_\_\_\_\_

Age\_\_\_\_\_Occupation\_\_\_\_\_

Date and place of birth\_\_\_\_\_Family physician\_\_\_\_\_

Emergency name & phone\_\_\_\_\_

How were you referred? \_\_\_\_\_

Chief complaint\_\_\_\_\_

\_\_\_\_\_

How long ago did this condition begin? \_\_\_\_\_

Other problems you want to work on\_\_\_\_\_

\_\_\_\_\_

Is this the first time you've had acupuncture?\_\_\_\_\_Craniosacral therapy?\_\_\_\_\_

## CONFIDENTIAL HEALTH HISTORY

**SYMPTOMS:** Check symptoms you currently have or have had in the past year.

### GENERAL

- Fatigue
- Insomnia
- Disturbed Sleep
- Frequent dreams/nightmares
- Intolerance to cold
- Intolerance to heat
- Weight loss
- Weight gain
- Fever
- Chills
- Unusual thirst
- Abdominal bloating/gas
- Swollen glands
- Belching
- Edema/swelling
- Other:

### SKIN

- Rashes
- Hives
- Night sweats
- Excessive daytime sweating
- Dry skin
- Bruise easily
- Changes in mole or lump
- Unusual bleeding
- Other:

### MUSCLES AND JOINTS

- Pain, weakness, numbness in:
- Arms
  - Legs
  - Hands
  - Feet
  - Hips
  - Shoulders
  - Neck
  - Back
  - Muscle cramps
  - Swollen joints
  - Other:

### NERVOUS SYSTEM

- Dizziness
- Fainting
- Paralysis
- Tremors
- Poor balance
- Seizures
- Other:

### EYES & EARS

- Failing vision
- Blurred vision
- Visual spots
- Night blindness
- Eye pain/swelling
- Ringing in ears
- Decreased hearing
- Ear pain
- Ear discharge
- Other:

### NOSE, THROAT, MOUTH

- Nosebleeds
- Unusual nasal discharge
- Frequent sneezing
- Change in sense of taste
- Sore throat
- Hoarseness
- Difficulty in swallowing
- Change in sense of taste
- Tooth or gum pain
- Mouth or tongue ulcers
- Other:

### HEART & LUNGS

- Palpitations
- Chest pain or tightness
- Rapid heartbeat
- Irregular heartbeat
- Swelling of ankles
- Coughing up blood
- Excessive phlegm
- Persistent cough
- Shortness of breath
- Asthma/wheezing
- Frequent colds/flu
- Other:

### MENTAL/EMOTIONAL

- Difficulty concentrating
- Poor memory
- Anxiety/worry
- Depression
- Irritability
- Excessive anger/rage
- Fearfulness
- Unusual stress
- Other:

### DIGESTIVE SYSTEM

- Nausea
- Vomiting
- Vomiting of blood
- Diarrhea
- Constipation
- Bloody/black stool
- Stomach pain
- Abdominal pain
- Poor appetite
- Excessive hunger
- Indigestion/heartburn
- Hemorrhoids
- Other:

### URINARY/GENITAL

- Painful urination
- Difficult urination
- Freq. daytime urination
- Freq. night urination
- Incontinence
- Bed-wetting
- Dark or cloudy urine
- Blood in urine
- Genital pain or itching
- Genital discharge
- Genital lesions
- Painful intercourse
- Low sexual energy
- Excessive sexual energy
- Other:

### MALE

- Impotence
- Weak urinary stream
- Lump in testicles
- Premature ejaculation
- Seminal emission
- Other:

### FEMALE

- Irregular periods
- Painful periods
- PMS
- Abnormal PAP smears
- Bleeding between periods
- Menopausal symptoms
- Breast lump
- Vaginal pain
- Other:

**SYMPTOMS, CONTINUED:**

**HEAD & NECK**

- Persistent headaches
- Stiff neck
- Jaw pain/TMJ
- Migraines     Grinding of teeth     Other:

**CONDITIONS:** Check conditions you currently have or have ever had in the past.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Prostate problems       |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Intestinal Disorder | <input type="checkbox"/> Psychiatric care        |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Scarlet fever           |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Gallbladder problem | <input type="checkbox"/> Lupus               | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> German measles      | <input type="checkbox"/> Measles             | <input type="checkbox"/> Stomach Disorder        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Thyroid Disorder        |
| <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis (A, B, C) | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Vaginal Infection       |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Venereal Disease        |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Other:                  |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Polio               | <input type="checkbox"/> Other:                  |

**FAMILY HISTORY: Fill in health information about your family.**

RELATION	Age:	State of health:	Cause of death, if deceased :
Mother	_____	_____	_____
Father	_____	_____	_____
Sisters	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Brothers	_____	_____	_____
_____	_____	_____	_____

**Check if your blood relations had any of the following:**

Disease:	Relation to you:
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Asthma, hayfever	_____
<input type="checkbox"/> Cancer (what type?)	_____
<input type="checkbox"/> Alcohol/chemical dependency	_____
<input type="checkbox"/> Diabetes (what type?)	_____
<input type="checkbox"/> Heart disease, stroke	_____
<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Other:	_____

**SURGERIES/HOSPITALIZATIONS:**

**PREGNANCY HISTORY:**

Year:	Hospital:	Reason & Outcome:	Year of birth:	Sex of birth:	Complications, if any:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**ACCIDENTS/FALLS/CONCUSSIONS:** List any car, bike, sports accidents and/or falls.

Year:	What happened?	Did you pass out?
_____	_____	_____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? { } YES { } NO

If yes, please give approximate dates and circumstances:

**MEDICATIONS:** List any medications and/or herbs you are taking:

prescription meds	over-the-counter meds	herbs, vitamins, supplements
_____	_____	_____
_____	_____	_____
_____	_____	_____

**HISTORY OF ANTIBIOTIC USE:** Please describe frequency and duration of use in lifetime IF MORE THAN ONE WEEK DURATION/ONCE EVERY TWO YEARS: \_\_\_\_\_

**DO YOU HAVE ANY AMALGAM DENTAL FILLINGS (MERCURY/METAL)?** \_\_\_\_\_

**ALLERGIES:** List any medications or other substances that you are allergic to.

\_\_\_\_\_

**HEALTH HABITS:** Check which substances you use and describe how often you use.

substance                      How much do you use and how often?

ALCOHOL \_\_\_\_\_

TOBACCO \_\_\_\_\_

COCAINE \_\_\_\_\_

MARIJUANA \_\_\_\_\_

CRYSTAL METH \_\_\_\_\_

OTHER \_\_\_\_\_

**EXERCISE:** Do you exercise regularly? { } Yes { } No

If yes, describe what type of activity and how often:

\_\_\_\_\_  
\_\_\_\_\_

**DIET:** Please describe your average daily diet:

# of caffeinated beverages/day: \_\_\_\_\_type(tea, coffee, etc.)\_\_\_\_\_

Morning:

Noon/afternoon:

Evening:

_____	_____	_____
_____	_____	_____
_____	_____	_____

**WHAT IS YOUR GENERAL STRESS LEVEL IN YOUR LIFE CURRENTLY?** \_\_\_\_\_

**IF APPLICABLE, PLEASE FILL OUT:**

Date of last menstrual period:

Date of last PAP smear:

Number of days between periods \_\_\_\_\_

Birth control? What type? \_\_\_\_\_

Date of last mammogram:

Are you pregnant? { } Yes { } No

Number of children:

Date of menopause:

Changes in body/emotions prior to period: \_\_\_\_\_

\_\_\_\_\_

**PLEASE SHARE ANY OTHER PROBLEMS/HEALTH ISSUES YOU WOULD LIKE TO DISCUSS:**

\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my acupuncturist responsible for any errors or omissions that I may have made in the completion of this form. I also understand the cancellation policy: I must provide 24 hours notice if I wish to cancel or reschedule an appointment, or I will be charged for that appointment. By signing below, I am also confirming that I understand the cancellation policy of the practice of Renée Hahn, Lic. Ac.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date