

**OPAL ACUPUNCTURE, LLC CLINICAL INTAKE FORM**

Date: \_\_\_/\_\_\_/\_\_\_

**Information provided on this form is confidential. Please print legibly.**

Name: \_\_\_\_\_ Sex:  Male  Female Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email address: \_\_\_\_\_

Telephone: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

Referred by: \_\_\_\_\_

What do you want treated with acupuncture? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ The onset was  sudden  gradual

Date of last physical exam: \_\_\_/\_\_\_/\_\_\_ Physician \_\_\_\_\_

Medical diagnosis, if any? \_\_\_\_\_

**Medicines/Supplements:**

Please check any of the following that you are now taking.		
<input type="checkbox"/> Aspirin or Ibuprofen	<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Antacids
<input type="checkbox"/> Oral Contraceptives	<input type="checkbox"/> Diet Pills	<input type="checkbox"/> Laxatives
<input type="checkbox"/> Sleeping Pills	<input type="checkbox"/> Allergy Medication	<input type="checkbox"/> Cold / Flu Medication
<input type="checkbox"/> Vitamins	<input type="checkbox"/> Herbs	<input type="checkbox"/> Other
Please list the names of any medication/herbs you are taking AND for what conditions.		

**Past Medical History: Please check any or all that apply:**

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hepatitis A/B/C           | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Herpes                    | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Lyme Disease              | <input type="checkbox"/> Thyroid Disorder    |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Multiple Sclerosis        | <input type="checkbox"/> Latex Allergy       |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Musculo-skeletal disorder | <input type="checkbox"/> Lymph nodes removal |
| <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Organ Transplant          | <input type="checkbox"/> Other               |

Comments: \_\_\_\_\_

**Food and Drink:**

How is your appetite? \_\_\_\_\_ Any food cravings? \_\_\_\_\_

List any food intolerances: \_\_\_\_\_

Describe typical meals: Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_

How often do you have: Meat: \_\_\_\_\_ Day/Week Dairy (milk, cheese, yoghurt) \_\_\_\_\_ Day/Week

What is your water intake? \_\_\_\_\_ 8 oz. glasses/day

Do you eat organic food? \_\_\_\_\_ % \_\_\_\_\_ Do you eat fast food? \_\_\_\_\_ % \_\_\_\_\_

**Gastrointestinal: CHECK current symptoms. CIRCLE symptoms that have affected you in the past**

- |   |  |
|---|--|
| <input type="checkbox"/> Belching             | <input type="checkbox"/> Bowel Movements.<br>How often? _____ day/week |
| <input type="checkbox"/> Nausea               | <input type="checkbox"/> Incomplete bowel movements                    |
| <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Painful bowel movements                       |
| <input type="checkbox"/> Vomiting blood       | <input type="checkbox"/> Irregular bowel movements                     |
| <input type="checkbox"/> Acid Regurgitation   | <input type="checkbox"/> Constipation                                  |
| <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Diarrhea                                      |
| <input type="checkbox"/> Indigestion          | <input type="checkbox"/> Gas   |
| <input type="checkbox"/> Severe stomach pain  | <input type="checkbox"/> Hemorrhoids                                   |
| <input type="checkbox"/> Bloating after meals | <input type="checkbox"/> Undigested food in stool                      |
| <input type="checkbox"/> Poor appetite        | <input type="checkbox"/> Blood in stool                                |
| <input type="checkbox"/> Excessive hunger     | <input type="checkbox"/> Itchiness and/or burning                      |
| <input type="checkbox"/> Other _____          | <input type="checkbox"/> Other _____                                   |

**Exercise and Energy and Temperature:**

How is your energy level (From 1 = lowest to 10 = highest)? \_\_\_\_\_

Do you fatigue easily? \_\_\_\_\_

What time of day is your energy: Highest? \_\_\_\_\_ Lowest? \_\_\_\_\_

What kind of exercise do you do? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_ Days/Week

Do you have any unusual sweating?  Yes  No When? \_\_\_\_\_

In general, does your core feel hot or cold? \_\_\_\_\_ Cold Hands & Feet? \_\_\_\_\_

**Habits: Please check off any of the habits that apply to you now or in the past:**

<input type="checkbox"/> Caffeine	_____ # of coffees/day _____ # of teas/day _____ # of sodas/day	<input type="checkbox"/> Stopped _____ years/months/days ago
<input type="checkbox"/> Tobacco	_____ # of cigarettes/cigars per day _____ # of packs/day _____ age began smoking	<input type="checkbox"/> Stopped _____ years/months/days ago
<input type="checkbox"/> Alcohol	_____ # of glasses per day _____ age began drinking	<input type="checkbox"/> Stopped _____ years/months/days ago
<input type="checkbox"/> Marijuana	_____ # used per day/week _____ age began using	<input type="checkbox"/> Stopped _____ years/months/days ago
<input type="checkbox"/> Hard drugs (cocaine, crack, heroin, LSD, etc.)	_____ specify frequency	<input type="checkbox"/> Stopped _____ years/months/days ago

**Emotions and Sleep:**

How do you feel emotionally? \_\_\_\_\_

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

- |   |   |
|---|---|
| <input type="checkbox"/> Panic attacks                    | <input type="checkbox"/> Poor memory              |
| <input type="checkbox"/> Nervousness                      | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Anxiety                          | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Fearfulness                      | <input type="checkbox"/> Frequent sighing         |
| <input type="checkbox"/> Anger, irritability, frustration | <input type="checkbox"/> Obsessive thoughts       |
| <input type="checkbox"/> Suicidal thoughts                | <input type="checkbox"/> Other                    |

Married/Stable Relationship    Single    Divorced    Widowed

How do you feel about your relationship? \_\_\_\_\_

Are you currently undergoing therapy? \_\_\_\_\_

Where do you hold stress \_\_\_\_\_

How do you relax? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

How long do you normally sleep? \_\_\_\_\_ hours per night. Do you feel refreshed in the morning? \_\_\_\_\_

I have difficulty with (please check any that currently apply):

- Falling asleep
- Staying asleep
- Disturbed sleep (dreams, light sleeper). Nightmares? \_\_\_\_\_
- Waking up at about \_\_\_\_\_ am/pm and not being able to fall back asleep because \_\_\_\_\_

**Urinary & Genital:**

I urinate approximately? \_\_\_\_\_ times per day. Color  pale yellow  dark yellow/brown/orange

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past:

- |  |   |
|--|---|
| <input type="checkbox"/> Trouble starting stream | <input type="checkbox"/> Dribbling when sneezing / coughing |
| <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Frequent urinary tract infections  |
| <input type="checkbox"/> Incontinence            | <input type="checkbox"/> Blood in urine                     |
| <input type="checkbox"/> Painful urination       | <input type="checkbox"/> Kidney stones                      |
|  | <input type="checkbox"/> Other _____                        |

How is your sexual energy? \_\_\_\_\_

What kind of birth control do you use? \_\_\_\_\_

Do you have (check all that apply)

- Infertility  
 Pain during sexual relations  
 other \_\_\_\_\_

**Women:**

Are you *currently* pregnant?  Yes  No      Are you *presently* trying to get pregnant?  Yes  No

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

Duration of flow \_\_\_\_\_ Color \_\_\_\_\_ Clots? \_\_\_\_\_ Quality (thick, thin) \_\_\_\_\_

Age of Menopause \_\_\_\_\_ How was your experience of menopause? \_\_\_\_\_

(Peri)Menopausal Symptoms: \_\_\_\_\_

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

- |  |  |
|--|--|
| <input type="checkbox"/> Irregular menses        | <input type="checkbox"/> Vaginal itching/burning                               |
| <input type="checkbox"/> Heavy flow              | <input type="checkbox"/> Discomfort / pain <b>before</b> menses                |
| <input type="checkbox"/> Light flow              | <input type="checkbox"/> Discomfort / pain <b>during</b> menses                |
| <input type="checkbox"/> No flow                 | <input type="checkbox"/> Discomfort / pain immediately <b>following</b> menses |
| <input type="checkbox"/> Spotting between menses | <input type="checkbox"/> Pelvic inflammatory disease                           |
| <input type="checkbox"/> Breast lumps            | <input type="checkbox"/> Other _____   |

PMS Symptoms \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_ Number of deliveries? \_\_\_\_\_ Abortions / Miscarriage(s)? \_\_\_\_\_

**Men:**

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past.

- |  |  |
|--|--|
| <input type="checkbox"/> Prostatitis       | <input type="checkbox"/> Penis blood / mucus discharge |
| <input type="checkbox"/> Impotence         | <input type="checkbox"/> Pain/ itching of genitalia    |
| <input type="checkbox"/> Lump in testicles | <input type="checkbox"/> Other _____                   |

**Respiratory: Nose, Throat, Ears, Eyes and Head**

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

- |  |  |
|--|--|
| <input type="checkbox"/> Frequent colds (3 or more per yr)                 | <input type="checkbox"/> Chronic cough   |
| <input type="checkbox"/> Chronic runny nose                                | <input type="checkbox"/> Coughing blood  |
| <input type="checkbox"/> Nose bleeds                                       | <input type="checkbox"/> Coughing phlegm   |
| <input type="checkbox"/> Changes in taste / smell<br>(please circle which) | Color _____ quantity _____   |
| <input type="checkbox"/> Dry mouth   | <input type="checkbox"/> Pain inhaling   |
| <input type="checkbox"/> Bleeding gums                                     | <input type="checkbox"/> Shortness of breath on exertion/ at rest<br>(please circle which) |
| <input type="checkbox"/> Cold sores  | <input type="checkbox"/> Difficulty swallowing   |
| <input type="checkbox"/> Other _____                                       | <input type="checkbox"/> Frequent sore throat  |

**Ears:**

- Ear pain
- Ringing in ears — high / low pitch
- Clogged / popping ears
- Decreased hearing
- Other \_\_\_\_\_

**Eyes:**

- Pain red eyes
- Poor vision
- See spots
- Dizziness
- Other \_\_\_\_\_

**Head:** Frequent Headaches / migraines. Please describe location and sensation \_\_\_\_\_

**Cardiovascular:**

Blood pressure \_\_\_\_\_ / \_\_\_\_\_ Have you ever been diagnosed with heart trouble?  Yes  No

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Chest pain     | <input type="checkbox"/> Phlebitis           |                                      |
| <input type="checkbox"/> Palpitations   | <input type="checkbox"/> Irregular heartbeat |                                      |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Poor circulation    | <input type="checkbox"/> Other _____ |

**Skin and Hair:**

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dry skin                  | <input type="checkbox"/> Hives           | <input type="checkbox"/> Bruise easily     |
| <input type="checkbox"/> Skin rashes               | <input type="checkbox"/> Psoriasis       | <input type="checkbox"/> Premature graying |
| <input type="checkbox"/> Itching                   | <input type="checkbox"/> Eczema          | <input type="checkbox"/> Hair loss         |
| <input type="checkbox"/> Acne                      | <input type="checkbox"/> Night sweating  | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Changes in moles or lumps | <input type="checkbox"/> Excess sweating |  |

Describe any significant injuries, surgeries, or major illnesses:

**Childhood Illnesses:** Age: \_\_\_\_\_

**Adolescence Illnesses:** Age: \_\_\_\_\_

**Adulthood:** Age: \_\_\_\_\_

Age: \_\_\_\_\_

Age: \_\_\_\_\_

**Muscles, Joints and Bones:**

Do you have pain or tightness? Where? \_\_\_\_\_

What is the current level of pain, from 1-10? \_\_\_\_\_

The pain feels worse with: \_\_\_\_\_

The pain feels better with: \_\_\_\_\_

The pain is: please check all that apply:

- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp       | <input type="checkbox"/> Dull         |
| <input type="checkbox"/> Superficial | <input type="checkbox"/> Deep         |
| <input type="checkbox"/> Tingling    | <input type="checkbox"/> Numb         |
| <input type="checkbox"/> Burning     | <input type="checkbox"/> Aching       |
| <input type="checkbox"/> Fixed       | <input type="checkbox"/> Moves around |

Other. Please describe \_\_\_\_\_

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

- |   |   |
|---|---|
| <input type="checkbox"/> Swollen joints           | <input type="checkbox"/> Tendonitis           |
| <input type="checkbox"/> Arthritis / joint pain   | <input type="checkbox"/> Rheumatism           |
| <input type="checkbox"/> Bone pain                | <input type="checkbox"/> Muscle cramps / pain |
| <input type="checkbox"/> Repetitive strain injury | <input type="checkbox"/> Weak muscles         |
| <input type="checkbox"/> Spinal curvature         | <input type="checkbox"/> Other                |

On the following diagram, please SHADE in the areas that you would like to be addressed.

**KEY: USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT**

<b>A = ACHE</b>
<b>B = BURNING</b>
<b>P = PINS &amp; NEEDLES</b>
<b>S = STABBING</b>
<b>N = NUMBING</b>
<b>O = OTHER</b>

