OPAL ACUPUNCTURE, LLC CLINICAL INTAKE FORM

Date: ________________

Information provided on this form is confidential.
You may complete this form online OR print a paper copy, fill it out legibly, and bring it to your first appointment.

Personal Information:

Name: ______________________________ Sex: ☐ Male ☐ Female Date of Birth: ____________

Address: __________________________ City: ____________ State: _____ Zip: _________ Age: _______

Occupation: _________________________________ Email Address: ____________________________

Telephone: ☐ Cell: ________________ ☐ Home: ________________ ☐ Work: ________________

*Check the box next to your preferred contact number. Referred by: __________________________

Emergency Contact: ____________________ Relationship: ______________ Phone: _________________

Condition Information:

In seeking acupuncture treatment, what condition(s) most concern you? _____________________________

____

____

How long have you had this condition? ___________________ The onset was ☐ sudden ☐ gradual

Describe what caused it or how it started: ____

____

____

Have you experienced this condition or similar conditions before? ___________________________________

____

If you have ever received treatment for this condition, what was the treatment? _________________________

____

When was the treatment and by whom? ____

If there was a diagnosis, what was it? ____

What were the results of the treatment? ____

____

Has this condition gotten … ☐ Better ☐ Worse ☐ About the same

What makes it better? ____

What makes it worse? ____

Date of last physical exam? ________________

Medicines/Supplements:

Please check any of the following that you are now taking:

☐ Aspirin or Ibuprofen	☐ Antidepressants	☐ Antacids
☐ Oral Contraceptives	☐ Diet Pills	☐ Laxatives
☐ Sleeping Pills	☐ Allergy Medication	☐ Cold/Flu Medication

Please list the names of any medications / vitamins / herbs you are taking, and why:

Past Medical History:

Please check any or all that apply:

☐ Alcoholism	☐ Heart Disease	☐ Organ Transplant
☐ Allergies	☐ Latex Allergy	☐ Seizures
☐ Asthma	☐ Lyme Disease	☐ Stroke
☐ Cancer	☐ Lymph Node Removal	☐ Thyroid Disorder
☐ Diabetes	☐ Multiple Sclerosis	☐ Weight Issues
☐ Emphysema	☐ Musculoskeletal Disorder	☐ Other

☐ Communicable Diseases (AIDS/HIV, Hepatitis A/B/C, Herpes, etc.)________________________

Describe any significant injuries, surgeries or major illnesses:

Childhood Illnesses (Age): ______________________________

Adolescence Illnesses (Age): ______________________________

Adult Illnesses (Age): ______________________________

Describe any family medical conditions that may be having a genetic impact on your current state of health:

Food and Drink:

Describe your appetite: ☐ Poor ☐ Up and Down ☐ Regular ☐ Excessively Hungry

Do you crave particular foods? ____________________

List any food intolerances: ____________________

Do you eat three meals a day? _______ At what times do you typically eat meals? ____________________

In a typical week, how often do you eat the following foods? (use approximate percentages)

Carbohydrates: _______ Vegetables: _______ Meat: _______ Dairy: _______

What is your water intake? _______ 8 oz. glasses/day Do you prefer warm or cold drinks? ______________

Please check "present" for current symptoms and "past" for symptoms that have affected you in the past.

Gastrointestinal:

Present	Past		Present	Past	
☐	☐	Acid regurgitation	☐	☐	Heartburn
☐	☐	Bad breath	☐	☐	Indigestion
☐	☐	Belching	☐	☐	Nausea
☐	☐	Bloating after meals	☐	☐	Severe stomach pain
☐	☐	Difficulty digesting fatty foods	☐	☐	Vomiting
☐	☐	Gallstones	☐	☐	Vomiting blood

Bowels:

I have bowel movements approximately ______ times per day.

Present	Past		Present	Past	
☐	☐	Incomplete bowel movements	☐	☐	Hemorrhoids
☐	☐	Painful bowel movements	☐	☐	Undigested food in stool
☐	☐	Irregular bowel movements	☐	☐	Blood in stool
☐	☐	Constipation	☐	☐	Itchiness and/or burning
☐	☐	Diarrhea	☐	☐	Gas

Urinary:

I urinate approximately _____ times per day. Color: ☐ pale yellow ☐ dark yellow/brown/orange

Present	Past		Present	Past	
☐	☐	Trouble starting stream	☐	☐	Dribbling when sneezing/coughing
☐	☐	Frequent urination	☐	☐	Frequent urinary tract infections
☐	☐	Incontinence	☐	☐	Blood in urine
☐	☐	Painful urination	☐	☐	Kidney stones

Exercise and Energy and Temperature:

In general, how is your energy level? (1=lowest, 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? __________ Do you have cold hands and feet? ______________

Habits:

Please check any of the habits that apply to you now or in the past, and record amounts:

Habit	Amount	Stopped
☐ Caffeine	______ ounces of coffee per day ______ ounces of tea per day ______ ounces of soda per day	☐ Stopped when? ______________
☐ Tobacco	______ cigarettes/cigars per day ______ packs per day ______ age began smoking	☐ Stopped when? ______________
☐ Alcohol	______ glasses of wine or beer per day ______ glasses of hard alcohol per day ______ age began drinking	☐ Stopped when? ______________
☐ Marijuana	______ times used per day/week ______ age began using	☐ Stopped when? ______________
☐ Hard drugs (cocaine, crack, heroin, LSD, etc.)	______ specify frequency	☐ Stopped when? ______________

Emotions:

Please check the frequency of each feeling that you ***currently*** experience					Please check the frequency of each feeling that you have experienced ***in the past***			
Never	Rarely	Occasionally	Frequently		Never	Rarely	Occasionally	Frequently
☐	☐	☐	☐	Panic attacks	☐	☐	☐	☐
☐	☐	☐	☐	Anxiety	☐	☐	☐	☐
☐	☐	☐	☐	Fearfulness	☐	☐	☐	☐
☐	☐	☐	☐	Anger, irritability, frustration	☐	☐	☐	☐
☐	☐	☐	☐	Poor memory	☐	☐	☐	☐
☐	☐	☐	☐	Difficulty concentrating	☐	☐	☐	☐
☐	☐	☐	☐	Depression	☐	☐	☐	☐
☐	☐	☐	☐	Frequent sighing	☐	☐	☐	☐
☐	☐	☐	☐	Difficulty making decisions	☐	☐	☐	☐
☐	☐	☐	☐	Cry easily	☐	☐	☐	☐
☐	☐	☐	☐	Obsessive thoughts	☐	☐	☐	☐
☐	☐	☐	☐	Other:______________________	☐	☐	☐	☐

Sleep:

How long do you normally sleep? _____hours per night   Do you feel refreshed in the morning?_______

What are the typical times you are asleep? ____

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

☐ Falling asleep ☐ Staying asleep ☐ Restless sleep

☐ Sleeping too much ☐ Disturbed sleep (dreams, light sleeper, nightmares)

☐ Waking up at about ____am/pm and not being able to fall back to sleep because ____________________

Head:

Present	Past		Describe frequency, location, and sensation:
☐	☐	Headaches	
☐	☐	Migraines	
☐	☐	Dizziness	
☐	☐	TMJ, teeth grinding or clenching	

Eyes:

Present	Past		Present	Past	
☐	☐	Painful, red or swollen eyes	☐	☐	Poor vision
☐	☐	Seeing spots	☐	☐	Dizziness
☐	☐	Other:			

Ears:

Present	Past		Present	Past	
☐	☐	Ear pain	☐	☐	Ringing in ears: ☐low pitch ☐ high pitch
☐	☐	Clogged/popping ears	☐	☐	Decreased Hearing
☐	☐	Other:			

Skin and Hair:

Present	Past		Present	Past	
☐	☐	Dry skin	☐	☐	Hives
☐	☐	Skin rashes	☐	☐	Psoriasis
☐	☐	Itching	☐	☐	Eczema
☐	☐	Acne	☐	☐	Night sweating
☐	☐	Changes in moles or lumps	☐	☐	Excess sweating
☐	☐	Bruise easily	☐	☐	Premature graying
☐	☐	Hair loss	☐	☐	Other:

Respiratory, Nose, Throat:

Present	Past		Present	Past	
☐	☐	Frequent colds (3 or more per year)	☐	☐	Chronic cough
☐	☐	Chronic runny nose	☐	☐	Coughing blood
☐	☐	Nose bleeds	☐	☐	Coughing phlegm
☐	☐	Changes in taste	☐	☐	Pain inhaling
☐	☐	Changes in smell	☐	☐	Shortness of breath upon exertion
☐	☐	Dry mouth	☐	☐	Shortness of breath at rest
☐	☐	Bleeding gums	☐	☐	Difficulty swallowing
☐	☐	Cold sores	☐	☐	Frequent sore throat
☐	☐	Sinus infections	☐	☐	Other:

Cardiovascular:

Blood Pressure: ____/____ Have you ever been diagnosed with heart trouble? ☐ yes ☐ no

Present	Past		Present	Past	
☐	☐	Chest pain	☐	☐	Phlebitis
☐	☐	Palpitations	☐	☐	Irregular heartbeat
☐	☐	Varicose veins	☐	☐	Poor circulation
☐	☐	Other:			

Muscles, Joints and Bones:

If you have pain or tightness, where is it? ____________________

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

Describe the pain (check all that apply):

☐ Sharp ☐ Dull ☐ Deep

☐ Superficial ☐ Numb ☐ Tingling

☐ Burning ☐ Aching ☐ Fixed

☐ Moves around ☐ Other (please describe): ____________________

Present	Past		Present	Past	
☐	☐	Swollen joints	☐	☐	Tendonitis
☐	☐	Arthritis/joint pain	☐	☐	Rheumatism
☐	☐	Bone pain	☐	☐	Muscle cramps/pain
☐	☐	Repetitive strain injury	☐	☐	Weak muscles
☐	☐	Spinal curvature	☐	☐	Other:

Sexual Information:

Describe your sexual energy: ☐ Low ☐ Up and Down ☐ Regular ☐ High ☐ N/A

What kind of birth control do you use? ____________________

Please check any that apply:

☐ Infertility ☐ Pain during sexual relations ☐ Other: ____________________

Men Only:

Present	Past		Present	Past	
☐	☐	Prostatitis	☐	☐	Penis blood/mucus discharge
☐	☐	Impotence	☐	☐	Pain/itching of genitalia
☐	☐	Lump in testicles	☐	☐	Other:

Women Only:

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) __________

PMS Symptoms? ______________________________

Age of Menopause: ________ How was your menopause experience? ______________________________

Number of pregnancies: ______ Number of deliveries: ______ Number of miscarriages and/or abortions: ______

Present	Past		Present	Past	
☐	☐	Irregular menses	☐	☐	Vaginal itching/burning
☐	☐	Heavy flow	☐	☐	Discomfort/pain **before** menses
☐	☐	Light flow	☐	☐	Discomfort/pain **during** menses
☐	☐	No flow	☐	☐	Discomfort/pain immediately **following** menses
☐	☐	Spotting between menses	☐	☐	Pelvic inflammatory disease
☐	☐	Breast lumps	☐	☐	Other:

Facial Rejuvenation Only (Skin History):

Surgeries: ______________________________ Botox and other fillers: ____________________

Sunscreen use: ______________________________ Do you bruise easily? ____________________

Products currently used: ______________________________

What do you like *most* about the appearance of your face and neck? ______________________________

____

What do you like *least* about the appearance of your face and neck? ______________________________

____

THANK YOU!