QiTender Acupuncture
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New Patient Intake:

This a confidential questionnaire that will help me to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask. Thank you.

Patient Name**:** _____Date: _____

Contact Information

Address: _____ City: _____ Zip: _____

DOB: _____ Preferred Phone: _____ ( ) Home ( ) Cell

Email Address: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Are you currently under the care of an MD? ( ) Yes ( ) No

Current diagnosis? _____

Physician's Name: _____ Specialty: _____

Physician Phone: _____

Main Concern

What is the primary reason for seeking acupuncture treatment?_____

_____

What was the initial cause? _____

How long have you had this condition? _____

What makes it worse? _____

What makes it better? _____

How does this condition interfere with your daily life? (Please Check Below)

( ) Work	( ) Standing	( ) Sexuality	Other _____	_____
( ) Sleep	( ) Emotional	( ) Recreation	_____	_____
( ) Walking	( ) Bending	( ) Relationships	_____	_____
( ) Sitting	( ) Social Life	( ) Stretching		

What other modalities have you tried? _____

What are currently doing any other modalities? If yes what. _____

Do you have any bleeding disorders? ( ) Yes ( ) No Explain: _____

Do you take any blood thinners? ( ) Yes ( ) No Explain: _____

****** **Are you pregnant or trying to conceive? ( ) Yes ( ) No**

Focused Concerns & Goals

Are you interested in: ( ) Pain Relief ( ) Holistic Health ( ) Herbal Therapy ( ) Other

( ) Stress Relief ( ) QI Gong ( ) Nutrition ( ) Preventive Care

( ) Maintenance Care

What are your heath goals?_____

Additional General Information

List any significant trauma & when it happened_____

_____

List any past dated or future sugeries_____

List exercises and sports activities you have been or are currently involved in _____

List any medications and dosages including supplements & herbs _____

_____

_____

Family Medical History

Please indicate if any family members have or have had any of the following conditions. (Check all that apply)

( ) Dementia ( ) Insomnia ( ) Sinus Issues ( ) Cancer ( ) Diabetes ( ) Hepatitis ( ) Stroke ( ) Hypertension

( ) Heart Disease ( ) Digestive Disorders ( ) Asthma ( ) Alcoholism ( ) Respiratory Issues ( ) Arthritis

( ) Mental Illness ( ) Tuberculosis ( ) Kidney Stones

Personal Medical History

Please list any of the above conditions that you may have or have had:

_____

_____

Do you have any allergies? ( ) Yes ( ) No

If so, what are they? _____

Are you allergic to any medications? ( ) Yes ( ) No

If so, what are they? _____

Do you sleep well? ( ) Yes ( ) No How many hours of restful sleep do you get each night? _____

Do you have difficultly ( ) falling asleep, ( ) staying asleep, or ( ) both? Do you wake rested? ( ) Yes ( ) No

Are you smoker? ( ) Yes ( ) No How many packs a day? _____ How long have you smoked? _____

How much (caffeinated) coffee, tea, soda, etc. do you drink per day? _____

How many alcoholic beverages do you consume in a week? _____ How many ounces of water do you drink a day?_____

Do you have a consistent 3 meals eating routine? ( ) Yes ( ) No If no briefly explain. _____

How late do you eat your last meal of the day? _____

Signs/Symptoms:

Please Indicate **C or P** if you ***have*** or have ***had*** any of the following conditions.

Mark each relevant box with **C** for *current condition* or **P** for a *past condition that no longer bothers you.*

General

	Poor Appitite		Night Sweats		Poor Balance		Easy Bleed/Bruise
	Insomnia		Sweats Easily		Weight Gain/Loss		Desire Hot/Cold Foods
	Fatigue		Tremors		Peculiar Tastes		Sudden Energy Drop
	Fever/Chills		Excessive Hunger		Strong Thirst		Dizziness

Musculoskeletal Pain Discomfort or Weakness

	Joint Pain		Cold Hands/Feet		Paralysis		Swelling Hands/Feet
	Muscle		Back Pain		Shoulder Pain		Difficulty Walking
	Hand/Wrist		Spine Curvature		Cramping		Neck Stiff/Pain
	Numbness		Hernis		Knee/Hip Pain		Whole Body Soreness

Skin/Hair

	Rash		Itching		Dandruff		Hair Loss
	Ulcerations		Eczema		Dry Skin		Purpura
	Hives		Pimples		Recent Moles		

Head/Eyes/Ear/Nose/Throat

	Concussion		Eye Strain/Pain		Cataracts		Blurry Vision
	Migraine		Night Blindness		Poor Vision		Difficulty Swallowing
	Ringin in Ears		Poor Hearing		Sinus Problems		Seeing Spots
	Nosebleeds		Sore Throat		Grinding Teeth		Teeth Issues
	Facial Pain		Jaw Clicking		Earaches		Sores on Lips/Tongue

Neuro-psychological/ Diagnosis

	Depression		Nervous		Loss of Balance
	Manic Depression		Anxiety		Lack of Coordination
	Poor Memory		Addictions		Obsessive/Compulsive
	Schizophrenia				

Respiratory

	Cough		Bronchitis		Wheezing		Difficulty Breathing
	Coughing Blood		Pneumonia		Chest Pains		Production fo Phlegm
							Color of _____

Emotional Health

	Easily Startled		Mania		Feeling Blah		Worry
	Angry/ Outburst		Irritability		Depression		Fearfulness
	Sadness		Grief		Vivid Dreams		Frequent Mood Changes

Cardiovascular

	Chest Pain		Palpitations		Fainting		High/Low Blood Pressure
	Phlebitis		Irregular Heartbeat		Varicose Veins		Slow/Fast Heart Rate

Genito-Urinary

	Pain with Urination		Blood in Urine		Frequent Urination		Urgent Urination
	Kidney Stones		Dark Urine		Dribbling		Pause of Flow
	Incontinence		Frequent UTI's		Genital Pain		Genital Itching

Gastrointestinal

	Nausea		Vomiting		Diarrhea		Constipation
	Gas/Bloating		Belching		Black Stools		Bloody Stools
	Indigestion		Bad Breath		Rectal Pain		Hemorrhoids
	Parisites		Chronic Laxative Use		Ulcers		Abdominal Pain/Cramps
	Gallbladder Issues		Mucus in Stools				

Bowel Movements: Frequency _____ times per day or _____ times per wk.

GENDER-SPECIFIC QUESTIONS: Please complete to relevant section below:

Male

	Prostate Problems		Discharge		Impotence		Frequent Seminal Emissions
	Painful swollen Testicles		Lack of Sex Drive		Genital Pain		Ejaculation Issues

Female Cycle Related issues

	Pelvic Infection		Endometriosis		Fibroids		Frequent Vaginal Infections
	Ovarian Cysts		Irregular Periods		Clotting		Vaginal Discharge
	Hot Flashes		PMS		Fertility Issues		Breast Lumps/Tenderness
	Mood Swings		Hysterectomy		Lack of Sex Drive		Pain/Cramping
	# of Pregnancies		# of Births		Difficult Deliveries		# Miscarriages
	Premature Births		Cesareans				

Date of Last Period _____ Age Started _____ Duration of Periods _____days Cycle _____ days

Do you have painful periods? ( ) Yes ( ) No If painful, when does pain occur? *(prior, during, after)* _____

If on birth control, what type and for how long? _____

Additional Questions

Briefly describe what is going well in your life.

If there is anything that you feel has been overlooked and you need to discuss, please Identify these concerns.

Guidelines and Objectives for Acupuncture Treatments:

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to Chinese Medicine and restore the body's balance and health. When the flow of energy in the body is disrupted, illness and disease occurs. This disruption of energy flow minimizes body's innate ability to heal itself.

Any health condition(s) or disease(s) presented by the patient will be treated according to governing the guidelines of Chinese Medicine and Acupuncture only. Treatment will relate only to the quantity, quality, and balance of energy. The only practice objective is to detect and correct the imbalances using Acupuncture and Traditional Chinese Medicine. Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of Acupuncture examination. Patients will be referred to qualified health care professional.

Please sign _____ **Date:**_____