EASTERN SCHOOL
OF ACUPUNCTURE AND TRADITIONAL MEDICINE

CLINIC INTAKE

Patient Name

First | Last | **Date**

Patient Email | **Patient Representative**

First | Last

Patient Home Phone | **Patient Cell Phone** | **Patient Work Phone**

Date of Birth | **Age** | **Highest Level of Education** | **Occupation**

Gender | **What gender were you at birth?** FEMALE MALE | **Marital Status** | **Height** | **Weight**

Patient Address

Country

City | **State** | **Zip Code**

Emergency Contact Name | **Emergency Contact Phone** | **Relationship**

First | Last

Physician's Full Name | **Physician's Phone** | **Physician's Diagnosis**

Allergies (environmental, food, medications)

440 FRANKLIN STREET, SUITE 550, BLOOMFIELD, NJ 07003 PHONE: 973-746-2848 FAX: 973-746-2088

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Initials Here

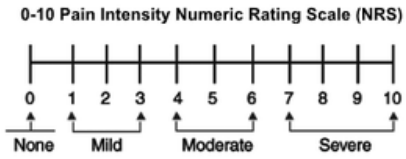
What is the problem that brought you here today?

When did this problem first appear?

Is it constant or does it come and go?

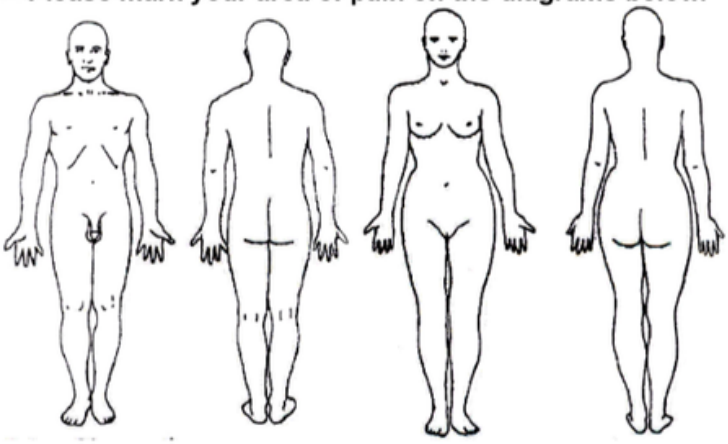
Are you experiencing pain right now? YES NO

If yes, what number best describes your pain?



NUMBER

Please mark your area of pain on the diagrams below.



Is your illness affected by seasonal changes? DESCRIBE

Are there other problems you would like addressed?

Do you ever experience dizziness? YES NO

Have you had acupuncture before? YES NO

Has there been anything that has ever been able to change your problem in any way? YES NO

If yes, please describe

If applicable, does the problem ever move? For example, pain or spasms that occur in different joints or muscles at different times. YES NO

Do you have a history of chronic pain? YES NO

What is the frequency of the pain?

CONTINUOUS INTERMITTANT

What makes your pain better? Check all that apply.

HEAT PRESSURE
COLD MASSAGE
REST MOVEMENT

Have you eaten today? YES NO

What time was your last meal?

Number of hours per night that you sleep

Do you have trouble falling to sleep? YES NO

Do you wake up very early and can't fall back asleep? YES NO

Do you wake up frequently? YES NO

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Have you ever smoked? YES NO

Do you still smoke? YES NO

If yes, how many cigarettes do you smoke daily?

If no, when did you quit?

Do you drink alcohol? YES NO

If yes, how many glasses per week?

Do you regularly experience abdominal pain? YES NO

If yes, what makes it better?

REST MASSAGE HEAT COLD
EATING NOT EATING MOVEMENT

Do you have any emotional difficulties? Please check all that apply.

REST ANXIETY MOOD SWINGS
MANIA DEPRESSION SEASONAL AFFECTIVE DISORDER

How would you rate your ability to maintain focused thinking and have clarity of thought?

GOOD EXCELLENT FAIR POOR

How would you rate your appetite?

GOOD EXCESSIVE FAIR POOR

Do you crave sweets? YES NO

What other foods do you crave?

Describe your bowel habits

REGULAR _____ TIMES PER DAY
CONSTIPATION DIARRHEA

If you suffer from constipation:

Do you feel better or worse after moving your bowels? BETTER WORSE

How many days pass before you move your bowels?

If you suffer from diarrhea:

Does it occur early in the morning when you first wake up? YES NO

How many episodes of diarrhea do you have per day?

How many times a day do you urinate per day?

Color of Urine

CLEAR PALE YELLOW DARK YELLOW

Volume of Urine

SCANT NORMAL ADUNDANT

Are you often thirsty? YES NO

What temperature do you prefer your drinks?

COLD WARM ROOM TEMPERATURE

Have you had your lymph nodes removed? YES NO

If yes, please describe

Do you have any infectious diseases? YES NO

If yes, please describe

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Do you often feel cold? YES NO

If yes, where? Please check all that apply.

LIMBS HANDS FEET ENTIRE BODY

Describe the degree to which you sweat

LITTLE AVERAGE EXCESSIVE

Do you sweat at night? YES NO

Do you exercise? YES NO

If yes, how often?

What type of exercise?

Please detail your diet
Eaten Daily

Number of vegetable portions

Number of meat product portions

Number of dairy product portions

Number of whole grain product portions

Number of caffeine products

Do you have a history of drug abuse? YES NO

How would you rate your energy level?

GOOD FAIR EXCELLENT POOR

FOR WOMEN ONLY

Chance that you could be pregnant? YES NO

Describe your menstrual cycles

EARLY LATE IRREGULAR REGULAR

How many days is your cycle from 1st day of bleeding to last day before next period?

How many days does your period last?

Describe your menstrual blood

DARK LIGHT NORMAL PURPLISH

Describe your menstrual flow

HEAVY LIGHT NORMAL

Number of pregnancies

Number of miscarriages

Number of abortions

Age of Menarche (first menstrual cycle)

Does your blood contain clots? YES NO

If yes, what color are the clots?

BRIGHT RED DARK IN COLOR

Are they larger than a quarter? YES NO

Do you have vaginal discharge? YES NO

Do you have itching or soreness of the vagina? YES NO

If you generally experience mood swings, describe how they are around the time of your menstrual cycle.

SAME NONE BETTER WORSE

Check symptoms that only appear prior to your period

SORE BREASTS MOOD SWINGS ANGER

HEADACHES BLOATING SADNESS

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List current medications, vitamins, and supplements
Dosage, Route, and Frequency

List any surgeries and/or hospitalizations
What type and when

Your History of Significant Illness - heart disease, measles, broken arm, etc.
Please include all past accidents, illnesses, and the date that they occurred.

Your Sibling(s) History of Significant Illness - heart disease, measles, broken arm, etc.
Please include all past accidents, illnesses, and the date that they occurred.

Your Parents' History of Significant Illness - heart disease, measles, broken arm, etc.
Please include all past accidents, illnesses, and the date that they occurred.

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Your Grandparents' History of Significant Illness - heart disease, measles, broken arm, etc.
Please include all past accidents, illnesses, and the date that they occurred.

Patient or Representative

Sign here

Relationship to the Patient

Date

Clinic Supervisor, L.Ac

Sign here

Print Name

Date

Eastern School of Acupuncture & Traditional Medicine Intern

Sign here

Print Name

Date

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