ACUPUNCTURE APPOINTMENTS

HILLTOP ACUPUNCTURE • DAVID YU, LAC
1661 ROUTE 27 2A, EDISON, NJ 08817 · 732-896-0461

Important things to remember regarding acupuncture treatment:

1. Please bring or wear loose clothing (shorts, t-shirts) to each appointment.
2. Please eat a light meal or snack before your appointment; an empty stomach may cause dizziness.

What to expect at your first visit?

Your first visit will take approximately one hour and will include an acupuncture treatment. We will discuss your health questionnaire and any concerns you have prior to the treatment. I will come up with a diagnosis, a treatment plan and a few suggestions regarding your condition.

ACUPUNCTURE CONFIDENTIAL INTAKE FORM

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(Please note that patients are required to fill out a new intake form EACH year to ensure that we have the most updated patient information.)

DATE: _____

PATIENT INFORMATION

Name: _____ Gender: _____

Age: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Occupation: _____

I. EXPERIENCE WITH ACUPUNCTURE

a. Have you received acupuncture treatment before? YES ☐ NO ☐

b. If yes, for what conditions and what was the outcome?

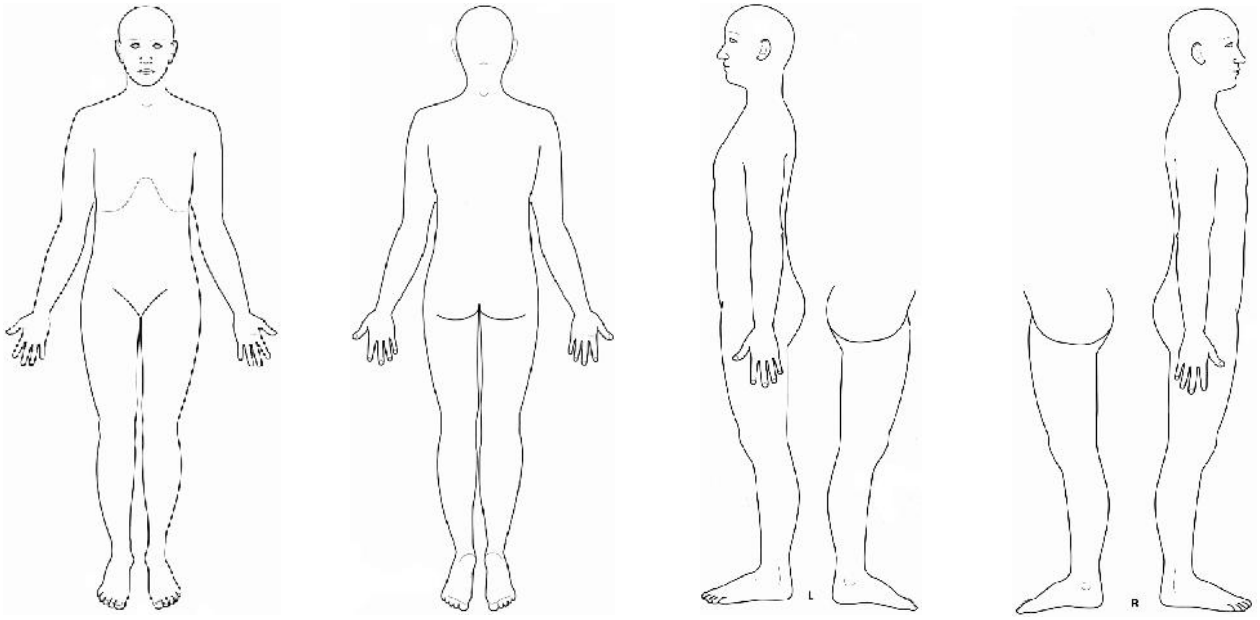
II. DESCRIPTION OF MAJOR COMPLAINTS

A. What are your main complaints?

1. **PRIMARY COMPLAINT:** _____ Onset ☐ sudden ☐ gradual?
   a. How long have you had this condition? _____
   b. Symptoms are better by: _____
   c. Symptoms are worse by: _____
   d. What medical diagnosis did you receive? _____
   e. Any other therapies? _____

2. **SECONDARY COMPLAINT**: _____ Onset ☐ sudden ☐ gradual?
   a. How long have you had this condition? _____
   b. Symptoms are better by: _____
   c. Symptoms are worse by: _____
   d. What medical diagnosis did you receive? _____
   e. Any other therapies? _____

B. On the diagram, please shade in the areas where you feel symptoms associated with your complaints.



III. MEDICATIONS, SUPPLEMENTS AND HERBS

A. Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking and the condition for which it is being taken:

_____

_____

B. LIST ANY ALLERGIES (to medications, supplements, herbs):

_____

C. Smoking, Alcohol & Drugs

1. Do you smoke tobacco? _____ If yes, do you believe that this is a problem for you? _____
2. Do you drink alcohol? _____ If yes, do you believe that this is a problem for you? _____
3. Do you use recreational drugs? _____ If yes, do you believe that this is a problem for you? _____

IV. PERSONAL MEDICAL HISTORY

A. BIRTH: Describe anything significant/traumatic about your birth:

B. VACCINATION HISTORY: Any unusual reaction? Any unusual vaccination?

C. ILLNESSES: Any surgery, accidents & /or major illnesses? Please indicate duration of illnesses.

AGE: _____

AGE: _____

AGE: _____

AGE: _____

V. FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER _____

FATHER _____

SIBLINGS _____

MATERNAL GRANDPARENTS _____

PATERNAL GRANDPARENTS _____

VI. SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

- **A = Acute (under 3 months)**
- **C = Chronic (over 3 months—experience at some point most days)**
- **F = Experience frequently (on & off)**

MUSCULOSKELETAL

- ☐ A C F Joint clicking
- ☐ A C F Limitation of movement
- ☐ A C F Stiffness
- ☐ A C F Spasms or cramps
- ☐ A C F Swelling
- ☐ A C F Weakness
- ☐ A C F Pain: Full body
- ☐ A C F Pain: Facial (e.g. jaw)
- ☐ A C F Pain: Neck
- ☐ A C F Pain: Upper Back
- ☐ A C F Pain: Mid Back
- ☐ A C F Pain: Low Back
- ☐ A C F Pain: Shoulder
- ☐ A C F Pain: Elbow
- ☐ A C F Pain: Wrist
- ☐ A C F Pain: Hand
- ☐ A C F Pain: Hip
- ☐ A C F Pain: Knee
- ☐ A C F Pain: Ankle
- ☐ A C F Pain: Foot
- ☐ A C F OTHER (Please list)

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EYES, EARS, NOSE & THROAT

- ☐ A C F Loss of vision
- ☐ A C F Eye pain
- ☐ A C F Tearing or eye dryness
- ☐ A C F Eye discharge
- ☐ A C F Eye redness
- ☐ A C F Ear discharge
- ☐ A C F Ear itching
- ☐ A C F Ear pain &/or infections
- ☐ A C F Loss of hearing
- ☐ A C F Ringing or buzzing in ears
- ☐ A C F Problems with balance (vertigo)

- ☐ A C F Olfaction (sense of smell) impaired
- ☐ A C F Nose obstruction (stuffiness)

- ☐ A C F Nose bleeds
- ☐ A C F Sinus pain, pressure &/or infections

- ☐ A C F OTHER (Please list)

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RESPIRATORY

- ☐ A C F Chest pain &/or tightness

- ☐ A C F Bluish discoloration of skin

- ☐ A C F Cough
- ☐ A C F Coughing up blood (hemoptysis)
- ☐ A C F Shortness of breath (dyspnea)

- ☐ A C F Sore throat
- ☐ A C F Sputum production
- ☐ A C F Voice changes
- ☐ A C F Wheezing
- ☐ A C F OTHER (Please list)

_____

CARDIOVASCULAR

- ☐ A C F Changes in skin temperature & color

- ☐ A C F Chest pain &/or pressure
- ☐ A C F Edema
- ☐ A C F Fainting (syncope)
- ☐ A C F Fatigue
- ☐ A C F Palpitations
- ☐ A C F Skin ulceration
- ☐ A C F Swelling of the ankles &/or legs

- ☐ A C F OTHER (Please list)

_____

DIGESTIVE

- ☐ A C F Abdominal distention/bloating
- ☐ A C F Abdominal mass
- ☐ A C F Abdominal pain
- ☐ A C F Acid regurgitation &/or Heartburn

- ☐ A C F Alternating constipation/diarrhea

- ☐ A C F Rectal bleeding
- ☐ A C F Constipation
- ☐ A C F Diarrhea
- ☐ A C F Gas
- ☐ A C F Eating disorder
- ☐ A C F Indigestion
- ☐ A C F Jaundice (yellow tint to skin &/or eyes)

- ☐ A C F Nausea
- ☐ A C F Vomiting
- ☐ A C F OTHER (Please list))

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UROGENITAL

- ☐ A C F Difficulty with urine flow
- ☐ A C F Incontinence
- ☐ A C F Painful urination (dysuria)
- ☐ A C F Rashes
- ☐ A C F Red urine
- ☐ A C F Urinary tract infection (UTI)
- ☐ A C F OTHER (Please list)

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NEUROLOGICAL

- ☐ A C F Changes in consciousness
- ☐ A C F Confusion
- ☐ A C F Difficulty concentrating
- ☐ A C F Dizziness
- ☐ A C F Dysphasia (impaired ability to speak)

- ☐ A C F Gait disturbance
- ☐ A C F Headache
- ☐ A C F Numbness and/or tingling
- ☐ A C F Loss of consciousness
- ☐ A C F Paralysis
- ☐ A C F Post shingles pain
- ☐ A C F Problems coordinating movements

- ☐ A C F Severe forgetfulness
- ☐ A C F Tremor
- ☐ A C F Visual disturbance
- ☐ A C F Weakness
- ☐ A C F OTHER (Please list)

_____

INTEGUMENTARY (SKIN)

- ☐ A C F Changes in hair
- ☐ A C F Changes in nails
- ☐ A C F Changes in skin color
- ☐ A C F Itching (pruritus)
- ☐ A C F Never sweat
- ☐ A C F Rash and/or skin lesion
- ☐ A C F Unusual sweating
- ☐ A C F Wounds that will NOT heal
- ☐ A C F OTHER (Please list)

_____

PSYCHOLOGICAL

- ☐ A C F Feelings of grief
- ☐ A C F Feeling of sadness
- ☐ A C F Feeling fearful/anxious/nervous

- ☐ A C F Difficulty managing anger

- ☐ A C F Feeling manic
- ☐ A C F Feeling worried or overly pensive

- ☐ A C F Feelings of panic
- ☐ A C F Feeling overwhelmed
- ☐ A C F Extreme mood swings
- ☐ A C F Extreme lack of emotion
- ☐ A C F OTHER (Please list)

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SLEEP

- ☐ A C F Difficulty falling asleep
- ☐ A C F Dream disturbed sleep
- ☐ A C F Wake up & cannot fall back asleep
- ☐ A C F OTHER (Please list)

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MISCELLANEOUS

- ☐ A C F Extremely low energy/fatigue
- ☐ A C F OTHER (Please list)

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FOR WOMEN ONLY

- ☐ A C F Abnormal vaginal bleeding
- ☐ A C F Changes in hair distribution

- ☐ A C F Fertility concerns
- ☐ A C F Irregular menstruation
- ☐ A C F Menopausal symptoms
- ☐ A C F No menses
- ☐ A C F Pain with menses (dysmenorrhea)

- ☐ A C F Pain during or after sexual relations

- ☐ A C F Pelvic pain
- ☐ A C F Premenstrual symptoms
- ☐ A C F Sexual dysfunction
- ☐ A C F Unusual discharge
- ☐ A C F OTHER (Please list)

_____

Are you pregnant OR TRYING to become pregnant?
YES ☐ NO ☐

Have you ever been pregnant? YES ☐ NO ☐ If yes, how many pregnancies: __

FOR MEN ONLY

- ☐ A C F Fertility concerns
- ☐ A C F Prostate problems
- ☐ A C F Sexual dysfunction
- ☐ A C F Unusual discharge
- ☐ A C F OTHER (Please list)

_____

VII. MEDICAL DISEASES/CONDITIONS.

Please check all that apply AND indicate (by circling) if it is chronic or if you had the problem in the past, but is now resolved.

- **C = Current condition**
- **P = Past condition, but is now resolved.**

☐ C P AIDS/HIV

☐ C P Alcoholism &/or substance addiction
☐ C P Allergies (If yes, pls indicate diagnosis & history)

_____

☐ C P Anemia
☐ C P Asthma
☐ C P Bell's Palsy
☐ C P Blood clotting disorder (If yes, pls indicate diagnosis & history)

_____

☐ C P Bipolar disorder
☐ C P Cancer (If yes, pls indicate diagnosis & history)

_____

☐ C P Chron's Disease &/or colitis
☐ C P Chronic Fatigue Syndrome (CFIDS)
☐ C P Depression (Major)
☐ C P Diabetes
☐ C P Eczema
☐ C P Endometriosis
☐ C P Fibroids
☐ C P Infertility
☐ C P Lung disease, e.g. COPD (If yes, pls indicate diagnosis & history)

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☐ C P Fibromyalgia
☐ C P Gallstones
☐ C P Heart disease (If yes, pls indicate diagnosis & history)

_____

☐ C P Hepatitis A / B / C
☐ C P Hernia
☐ C P Herpes
☐ C P Hypertension
☐ C P Hypoglycemia
☐ C P Irritable Bowel Syndrome (IBS)
☐ C P Joint Replacement (If yes, pls indicate diagnosis & history)

_____

☐ C P Kidney Stones and/or Disease (If yes, pls indicate diagnosis & history)

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☐ C P Lupus
☐ C P Lyme Disease
☐ C P Lymph node removal
☐ C P Mitral valve prolapse
☐ C P Mood Disorder

☐ C P Mononucleosis
☐ C P Multiple Sclerosis
☐ C P Organ removal or transplant (If yes, pls indicate diagnosis & history)

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☐ C P Osteoarthritis
☐ C P Osteoporosis
☐ C P Pacemaker (heart or stomach)
☐ C P Parkinson's Disease
☐ C P Pelvic Inflammatory Disease
☐ C P Polio
☐ C P Psoriasis
☐ C P PTSD (Post-Traumatic Stress Disorder)
☐ C P Reflux esophagitis (GERD)
☐ C P Rheumatic fever
☐ C P Rheumatoid arthritis
☐ C P Scarlet Fever
☐ C P Schizophrenia
☐ C P Scoliosis
☐ C P Seizures and /or epilepsy
☐ C P Shingles
☐ C P Sleep Disorder
☐ C P Stroke
☐ C P Schizophrenia
☐ C P Thyroid disease (If yes, pls indicate diagnosis & history)

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☐ C P Ulcer
☐ C P Trigeminal Neuralgia
☐ C P Tuberculosis
☐ C P Vascular disease (e.g. phlebitis) (If yes, pls indicate diagnosis & history)

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☐ C P OTHER (pls list)

_____