Aquino Acupuncture
& HOLISTIC HEALTH

# NEW PATIENT INTAKE FORM

| Patient Name: | Date: |
|---|---|

| What are the main issues for which you are seeking treatment today? |
|---|
| |
| |
| |
| |
| When did this begin? |
| What makes it better? |
| What makes is worse? |
| Is this injury work-related? ☐ Yes ☐ NO Date of Accident: ______________ |
| Is this injury due to an auto accident? ☐ Yes ☐ NO Date of Accident: ______________ |
| Have you received treatment for this condition before? ☐ Yes ☐ NO |
| If yes, what type of treatment? |
| Were you given a diagnosis? |
| Have you had the same or similar symptoms in the past? ☐ Yes ☐ NO |
| Does anyone in your family have the same condition? ☐ Yes ☐ NO |
| **FOR INTERNAL USE ONLY** |
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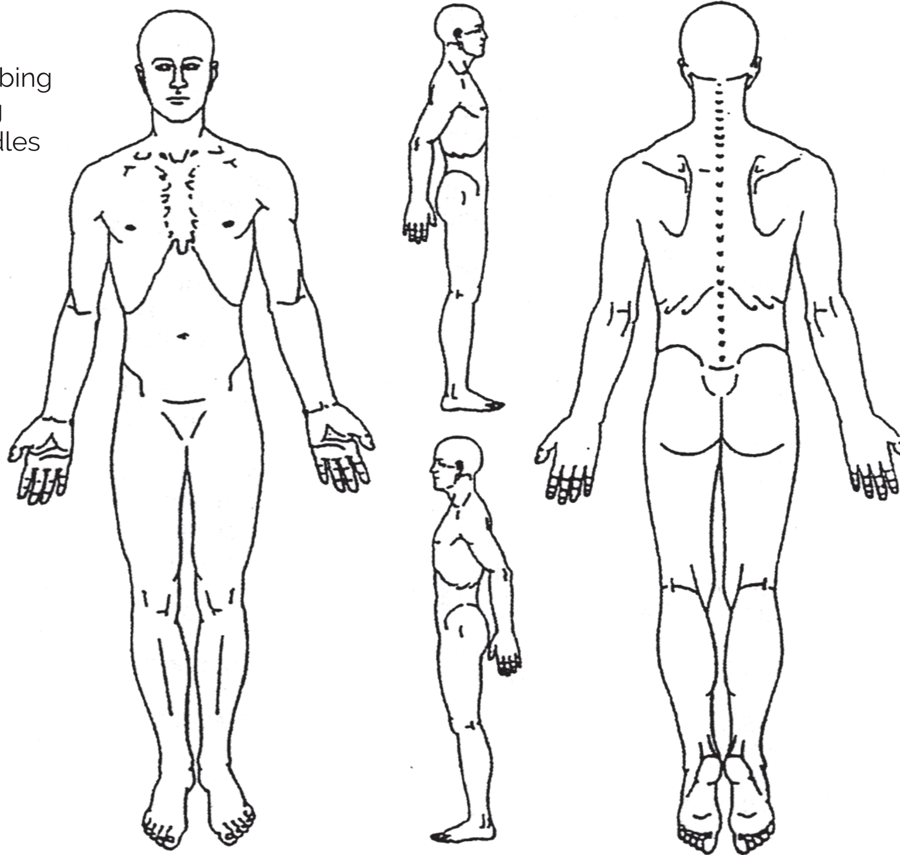
| |

| Patient Name: | Date: |
|---|---|

Are you experiencing discomfort in any area of your body? Yes ☐ No ☐

If yes, using the models below, please indicate the appropriate location of the discomfort by using the symbol that best describes the feeling:

+++ Sharp/Stabbing
vvv Dull/Aching
ooo Pins & Needles
/// Numbness



**THE PAIN INDICATED ABOVE IS**

Mild ☐ Moderate ☐ Severe ☐

**Please check the appropriate square to describe your present limitations in function due to the pain indicated above**

| ACTIVITY | NORMAL | MILDLY LIMITED | MODERATELY LIMITED | SEVERELY LIMITED |
|---|---|---|---|---|
| Lifting | ☐ | ☐ | ☐ | ☐ |
| Bending | ☐ | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ | ☐ |
| Climbing Stairs | ☐ | ☐ | ☐ | ☐ |
| Running | ☐ | ☐ | ☐ | ☐ |
| Resting in bed | ☐ | ☐ | ☐ | ☐ |
| Intercourse | ☐ | ☐ | ☐ | ☐ |
| Data entry/typing | ☐ | ☐ | ☐ | ☐ |

Does your condition interfere with your normal work, household or recreational activities? Yes ☐ No ☐
If yes, please explain:

| Patient Name: | Date: |
|---|---|

| MEDICATION HISTORY — Please list any medications you are currently taking. | | |
|---|---|---|
| MEDICATION/SUPPLEMENTS | REASON | HOW LONG? |
| | | |
| | | |
| | | |
| | | |
| | | |

| Please list any accidents, surgeries or hospitalizations. | |
|---|---|
| EVENT | YEAR |
| | |
| | |
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| | |

## MEDICAL HISTORY

Please check the symptoms/illness you have been diagnosed with or experienced.

- ☐ Allergies
- ☐ Anemia
- ☐ Aneurysm
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
  - ☐ Rheumatoid
  - ☐ Osteo
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Chronic Fatigue Syndrome
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Epstein Barr Virus
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
  - ☐ B
  - ☐ C
- ☐ Herpes Zoster (Shingles)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Seizures
- ☐ Thyroid Disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/growth
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Whooping Cough
- ☐ Other (specify below)

## FAMILY HISTORY

Has any member of your family had any of the above? ☐ Yes ☐ No

If yes, which family member and what did they have?

Please check the symptoms/illness you have experienced within the past six months

| EARTH ELEMENT | METAL ELEMENT | WATER ELEMENT | WOOD ELEMENT | FIRE ELEMENT | MISCELLANEOUS |
|---|---|---|---|---|---|
| ☐ Clammy hands | ☐ Bronchitis | ☐ Swollen ankles | ☐ Anemia | ☐ Angina pains | ☐ Dry skin |
| ☐ Lack of appetite | ☐ Cough | ☐ Burning with urination | ☐ Bitter taste in mouth | ☐ Anxiety | ☐ Water retention or swelling |
| ☐ Low blood sugar | ☐ Chest congestion | ☐ Frequent urination | ☐ Difficulty digesting oily or fatty foods | ☐ Frequent crying | ☐ High energy |
| ☐ Sweet cravings | ☐ Shortness of breath | ☐ Frequent urination at night | ☐ Difficulty making plans or decisions | ☐ Heat intolerance | ☐ Fatigue or tendency to faint |
| ☐ Loose Stool or undigested food | ☐ Decreased sense of smell | ☐ Urine retention | ☐ Easily angered or agitated | ☐ Nervousness | ☐ Tendency to be hot |
| ☐ Afternoon Slump | ☐ Feeling of claustrophobia | ☐ Painful urination | ☐ Eye problems (tearing, itching, blurred vision) | ☐ Nightmares | ☐ Tendency to be cold |
| ☐ Nausea | ☐ Fever | ☐ Kidney stones | ☐ Gall stones | ☐ Poor memory | ☐ Weight loss: ____________ (#lbs/time frame) |
| ☐ Drowsiness | ☐ Frequent sore throats | ☐ Cold intolerance | ☐ Hemorrhoids | ☐ Irregular heart-rate | ☐ Weight Gain: ____________ (#lbs/time frame) |
| ☐ Tendency to be "obsessive" | ☐ Asthma | ☐ Decreased sex drive | ☐ Hepatitis | ☐ Pressure in chest | |
| ☐ Fatigue after a meal | ☐ Nasal problems | ☐ Hair loss | ☐ High cholesterol | ☐ Easily excitable | |
| ☐ Food Sensitivity | ☐ Recent use of antibiotics | ☐ Knee problems | ☐ Impatience | ☐ Mental confusion | |
| ☐ Easily bruised | ☐ Frequent colds | ☐ Night sweats | ☐ Depression | ☐ Insomnia | |
| ☐ Indigestion | ☐ Chills | ☐ Fearful | ☐ Light colored stool | | |
| ☐ Vomiting | ☐ Constipation | ☐ Ringing in ears | ☐ Pain under ribs | | |
| ☐ Tendency to worry | ☐ Blood in stool | ☐ Burning hands or feet | ☐ Soft/brittle nails | | |
| ☐ Bloating | ☐ Skin problems type__________ | ☐ Blood in urine | ☐ Spasm or twitching muscles | | |
| | ☐ Inhalation of toxic chemicals | ☐ Low blood pressure | ☐ Stiff neck/ shoulders | | |
| | ☐ Swollen lymph glands | ☐ Salt craving | ☐ Tightness in ribs | | |
| | ☐ Allergies | ☐ Stress | ☐ Varicose veins | | |
| | ☐ Infections | ☐ Sleeplessness | ☐ Anger | | |
| | ☐ Chronic Illness | ☐ Dizziness | ☐ High blood pressure | | |
| | ☐ Sweating without exercise | ☐ Dark circles under eyes | ☐ Fever Blisters | | |
| | ☐ Intolerant to weather changes | ☐ Low back pain | | | |
| | | ☐ Hearing impairment | | | |
| | | ☐ Afternoon fever | | | |

| Patient Name: | Date: |
|---|---|

| Please indicate the use and frequency of the following: | | | | | |
|---|---|---|---|---|---|
| | YES | NO | HOW MUCH? | HOW OFTEN? | MOST EVER USED? |
| Coffee/Tea | | | | | |
| Recreational drugs | | | | | |
| Tobacco | | | | | |
| Alcohol | | | | | |
| Water | | | | | |
| Soda | | | | | |
| Refined Sugar | | | | | |
| | TYPE (S) | | | FREQUENCY | |
| Exercise | | | | | |
| Hobbies | | | | | |

| Describe your dietary/nutritional habits (what do you eat?) | List any allergies, food sensitivities or cravings that you have |
|---|---|
| | |
| | |
| | |

| Please check the appropriate box if you experience sensitivity to any of the following items | | |
|---|---|---|
| Perfume | | **Please Describe**: |
| Insecticides | | |
| Fabrics | | |
| Other Chemicals | | |

Do you currently work with or around chemicals? Yes ☐ No ☐

**If yes, please describe:**

| How do you feel about the following areas of your life? | | | | | |
|---|---|---|---|---|---|
| | GREAT | GOOD | FAIR | POOR | BAD |
| Significant other | | | | | |
| Family | | | | | |
| Diet | | | | | |
| Sex | | | | | |
| Self | | | | | |
| Work | | | | | |
| Exercise | | | | | |
| Spirituality | | | | | |

| Please rate how your primary complaint affects the following aspects of your health. | | | | | | |
|---|---|---|---|---|---|---|
| | NO PROBLEM | OCCASIONAL PROBLEM | MILD PROBLEM | MODERATE PROBLEM | SEVERE PROBLEM | NOT APPLICABLE |
| Energy Level | 1 | 2 | 3 | 4 | 5 | NA |
| Appetite | 1 | 2 | 3 | 4 | 5 | NA |
| Sleep Patterns | 1 | 2 | 3 | 4 | 5 | NA |
| Pain | 1 | 2 | 3 | 4 | 5 | NA |
| Digestion | 1 | 2 | 3 | 4 | 5 | NA |
| Elimination | 1 | 2 | 3 | 4 | 5 | NA |
| Emotions | 1 | 2 | 3 | 4 | 5 | NA |

Using the scale above, how would you rate the intensity of your primary complaint

| Patient Name: | Date: |
|---|---|

## Females - Gynecological History

Age began Menstruating

Is your menstrual cycle regular? ☐ Yes ☐ No

If post-menopausal, age at which menses stopped ________

**If you have stopped menstruating are you experiencing any difficult symptoms since your period has ended?**

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Mood Swings
- ☐ Bone Loss
- ☐ Weight Gain
- ☐ Dry Skin
- ☐ Vaginal Dryness
- ☐ Insomnia
- ☐ Urine leaking with sneeze or cough
- ☐ Low Sex Drive
- ☐ Other: ______________________ ______________________

Date of the first day of your last period: ________

How long is your cycle usually? ________ days
(count from Day 1 of bleeding to next day 1 of bleeding)

How many days do you normally bleed? ________
Do you have spotting before or after full flow?

Type of flow ☐ Light ☐ Heavy ☐ Medium ☐ Clots

Color of Blood ☐ Pale ☐ Red ☐ Bright red ☐ Dark red ☐ Purplish ☐ Brownish ☐ Black

Do you have bleeding at other times of the month?
☐ No ☐ Yes when? ______________

**Do you notice any of the following symptoms premenstrually or at any other time of your cycle?**

- ☐ Abdominal Bloating
- ☐ Irritability
- ☐ Irritability/Frustration
- ☐ Sadness
- ☐ Nervousness/Anxiety
- ☐ Fatigue
- ☐ Constipation
- ☐ Diarrhea
- ☐ Salt Cravings
- ☐ Fat/Oil Cravings
- ☐ Sweet Cravings
- ☐ Hot flashes
- ☐ Night Sweats
- ☐ Dizziness
- ☐ Palpitations
- ☐ Headaches
- ☐ Breast Tenderness
- ☐ Breast lumps
- ☐ Brain Fog
- ☐ Insomnia
- ☐ Acne
- ☐ Sore lower Back
- ☐ Painful Intercourse
- ☐ Vaginal Dryness

Do you have any pain with your period?
☐ None ☐ Mild ☐ Moderate ☐ Severe

When?
☐ Before Flow ☐ Day 1 ☐ Day 2 ☐ After period
☐ other ______________________________

Where?
☐ Low abdomen ☐ Low Back ☐ Rectovaginal
☐ Down thighs

What makes it better? ________________________________

Check any of the following you notice at ovulation or midcycle:
☐ Pelvic twinges ☐ Increased vaginal discharge
☐ Stronger sex drive ☐ Pelvic pain

Do you need to lubrication including saliva to make intercourse more comfortable? ☐ Yes ☐ No

Do you have vaginal Discharge at other times of your cycle?
☐ No ☐ Yes

If yes please describe amount, color, any odor?
______________________________________________

Have you had an abnormal PAP result?
☐ No ☐ Yes If Yes, when and class ________

Have you had a mammogram? ________
If yes, when? ________ Any Findings? ________

Do you do Breast Self Exams? ________
If yes how often? ________ Any Findings? ________

**Have you ever been diagnosed with any of the following:**

- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Breast lumps
- ☐ Fibrocycstic Breasts
- ☐ Ovarian Cysts
- ☐ Cervical or uterine cancer
- ☐ Polycystic Ovarian Syndrome
- ☐ Yeast Infections
- ☐ Genital Herpes
- ☐ Chlamydia
- ☐ HIV/ARC
- ☐ Gonorrhea
- ☐ Syphilis

Birthing History
No. of Pregnancies ____ Live Births____ Miscarriages____
Ectopic____ Difficult labors? ________________________

Any pre-term Deliveries? ____ Any Cesarean Deliveries? ____

☐ Gestational Diabetes ☐ Pre-eclampsia
☐ Thyroid problems before or after delivery ☐ Hypertension

Any problems with lactation?

Any post-partum health problems?

Is there anything else you would like to discuss?
______________________________________________
______________________________________________
______________________________________________

| Patient Name: | Date: |
|---|---|

## For Males Only

**Check the corresponding box and sub-categories if you have ever had any of the following:**

- ☐ Testicular swelling/pain
- ☐ Premature ejaculation
- ☐ Nocturnal emissions
- ☐ Weak or slow urine stream
- ☐ Dribbling urination
- ☐ Burning urination
- ☐ Discharge from penis
- ☐ Rectal/anal pressure
- ☐ Sexually transmitted diseases
  - ☐ HIV/ARC
  - ☐ Genital herpes
  - ☐ Chlamydia
  - ☐ Gonorrhea
  - ☐ Syphilis
- ☐ Impotence
- ☐ Decreased sex drive
- ☐ Increased sex drive
- ☐ Low sperm count

## Is there anything else you would like to explain regarding your condition?

## FOR INTERNAL USE ONLY

## CANCELLATION POLICY

Appointments must be canceled or changed within 24 hours of your appointment time. Without notice, the full cost of the visit will be incurred.

I understand the above cancellation policy.

Signature ____________________ Date ____________