In Good Health

Initial Intake Form

Lana Farson, Licensed Acupuncturist and Herbalist
3441 Golden Gate Way, Suite H • Lafayette, CA 94549 • 510-847-6459

Today's date ____/____/____

Thank you for taking the time to complete the following information which will better help me to access your health needs. All information is confidential. I will be happy to answer any questions you may have.

Name _____ Age _____ Birth date ____/____/____ Gender _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____ email _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partnership ☐ Referred by _____

Emergency contact _____ Relationship _____

Emergency contact home phone _____ Work phone _____

Physician's name/city _____ Date of last visit ____/____/____

Employment - Please check all that apply.

Full-time ☐ Part-time ☐ Student ☐ Unemployed ☐ Retired ☐ Occupation _____

Hours of work/study per week _____ Hours spent driving per week _____

Employer's name _____ Location _____

Payment

Account paid by: Self ☐ Worker's Comp ☐ Other _____

Payment in full is due at the time services are rendered. Upon request a Superbill can be provided for you to submit directly to your insurance company to seek reimbursement for payments made. You may call your insurance company to inquire if acupuncture services are covered under your policy.

Primary Insurance _____ Phone _____

Primary Insurance Address _____

Policy Holder's Name _____ Relationship _____

Policy #/ID #/Subscriber # _____ Group # _____

Medicines, Herbs, and Supplements – Check any medicine you are currently taking.

Aspirin ☐ Ibuprofen/Advil/Motrin ☐ Acetaminophen (Tylenol) ☐ Antacids ☐ Diet pills ☐ Laxatives ☐ Insulin ☐

Sleeping pills ☐ Allergy medication ☐ Blood thinners ☐ Blood pressure pills ☐ Oral contraceptives ☐

Tranquilizers ☐ Anti-depressants ☐ Please list drug names _____

Herbs _____ Supplements/Vitamins _____

Medication allergies _____ Food allergies _____

Please describe your typical daily diet:

Breakfast _____ Morning snack _____

Lunch _____ Afternoon snack _____

Dinner _____ Evening snack _____

Do you eat a vegan diet?____ Can you take remedies containing animal products? _____

Have you ever had acupuncture before? Yes ☐ No ☐ If yes, for what condition?

Do / Did you smoke tobacco? Yes ☐ No ☐ Length of time? _____ Amount? _____

Did you quit? Yes ☐ No ☐ Year quit? _____ Can you drink alcohol? (some remedies contain alcohol) Yes ☐ No ☐

Please indicate amount per day/week consumed of the following: Alcohol _____ Marijuana _____

Family History - Place an X in the appropriate box indicating condition for each family member:

	Self	Mother	Father	Sister	Brother	Spouse	Child		Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies/asthma	☐	☐	☐	☐	☐	☐	☐	Drug abuse	☐	☐	☐	☐	☐	☐	☐
Blood disorder/anemia	☐	☐	☐	☐	☐	☐	☐	Alcohol abuse	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	Heart disease	☐	☐	☐	☐	☐	☐	☐
Cancer /tumors	☐	☐	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	Depression	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	Mental condition	☐	☐	☐	☐	☐	☐	☐
Kidney disease/stone	☐	☐	☐	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Stomach/intestinal	☐	☐	☐	☐	☐	☐	☐	Age at death	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	_____							

List any illnesses in your immediate family (mother, father, siblings, grandparents) _____

_____

Please list any serious diseases, hospitalizations, injuries, accidents or surgeries you have had and give approximate dates (if you need more space, use back). _____

_____

_____

Chose one or two emotions that seem predominant in your life (frequently experienced, difficult to express, or in some way influential). _____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g., divorce, injury, death in family, bankruptcy, etc.).

Date ____/____/____ Event_____ Date ____/____/____ Event_____

Date ____/____/____ Event_____ Date ____/____/____ Event_____

Date ____/____/____ Event_____ Date ____/____/____ Event_____

Describe your current program of fitness. _____

Do you have a religious or spiritual practice? If so, what? _____

What are your goals for your health?_____

Total # pregnancies_____ Living_____ Abortions_____ Miscarriages_____

Date of last menses ____/____/____ # days in cycle _____

Social History

Birthplace: _____ Places you were raised: _____

A major source of JOY in my life is:_____

A major source of STRESS in my life is:_____

Have you been outside the U.S. in the past 12 months: Yes ☐ No ☐ Where? _____

Tests and Immunizations

Please list date of most recent visit:

Chest X-ray	_____	Sigmoidoscopy	_____	EKG	_____	Stool Blood Test	_____
Mammogram	_____	TB Skin Test	_____	Pap Smear	_____	Complete Physical	_____
GI Series	_____	Flu Shot	_____	Pneumonia Shot	_____	Other	_____

Please place a checkmark in the box marked “Present” for any symptoms you are currently experiencing, and in the box marked “Past” for any symptoms you have previously experienced.

Symptoms of **Water** Element

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Decreased hearing	☐	☐	Kidney stones	☐	☐	Urine incontinence	☐	☐	Pelvic inflammatory disease
☐	☐	Ear ringing	☐	☐	Sweating (day/night)	☐	☐	Bowel incontinence	☐	☐	Irregular periods
☐	☐	Dizziness	☐	☐	Weakness of legs	☐	☐	Frequent urination	☐	☐	Premenstrual syndrome
☐	☐	Lower back ache	☐	☐	Weakness of knees	☐	☐	Burning urination	☐	☐	Painful menstrual periods
☐	☐	Neck pain	☐	☐	Asthmatic cough	☐	☐	Weak urine stream	☐	☐	Abnormal bleeding
☐	☐	Edema	☐	☐	Rapid weight change	☐	☐	Urinary tract infections	☐	☐	Menopause symptoms
☐	☐	Darkness under eyes	☐	☐	Loose teeth	☐	☐	Sore knees	☐	☐	Breast lumps
☐	☐	Emotional instability	☐	☐	Reduced sexual energy	☐	☐	Cravings for salty foods	☐	☐	Impotence
☐	☐	Aversion to cold	☐	☐	Thyroid problems	☐	☐	Frequent feelings of fear	☐	☐	Premature ejaculation
☐	☐	Chronic sore throat	☐	☐	Diabetes	☐	☐	Blood in urine	☐	☐	Testicular lumps

Symptoms of **Wood** Element

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High blood pressure	☐	☐	Blurred vision	☐	☐	Anxiety/stress
☐	☐	Migraines	☐	☐	Indecisiveness	☐	☐	Poor eyesight	☐	☐	Fainting
☐	☐	Dry eyes	☐	☐	Insomnia 11pm-3am	☐	☐	Poor night vision	☐	☐	Seizures
☐	☐	Eczema	☐	☐	Numbness of limbs	☐	☐	Floaters (in visual field)	☐	☐	Fibroids
☐	☐	Nervousness	☐	☐	Tremors	☐	☐	Visual changes			
☐	☐	Irritability	☐	☐	Depression	☐	☐	Glasses/contact lenses			
☐	☐	Vomiting	☐	☐	Tendency to anger easily	☐	☐	Eye infections			

Symptoms of **Fire** Element

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Dry scalp	☐	☐	Bitter taste in mouth	☐	☐	Herpes simplex	☐	☐	Chest pain/pressure
☐	☐	Skin eruptions/rashes	☐	☐	Nose bleed	☐	☐	Itching/burning skin	☐	☐	Nausea
☐	☐	Ear infections	☐	☐	Facial redness	☐	☐	Gallstones	☐	☐	Cataracts
☐	☐	Lymphatic swelling	☐	☐	Excessive/vivid dreams	☐	☐	Strong thirst	☐	☐	Cold hands/feet
☐	☐	Hot palms and soles	☐	☐	Grinding teeth	☐	☐	Fullness below ribs	☐	☐	Sharp pains
☐	☐	Shingles	☐	☐	Dizziness	☐	☐	Dark urine	☐	☐	Paralysis
☐	☐	Aversion to heat	☐	☐	Sciatica/nerve pain	☐	☐	Red eyes	☐	☐	Tendinitis

Symptoms of **Earth** Element

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Indigestion	☐	☐	Sores in mouth	☐	☐	Decreased ability to taste	☐	☐	Anal fissures
☐	☐	Flatulence	☐	☐	Heartburn	☐	☐	Feeling of pensiveness	☐	☐	Vomiting
☐	☐	Food allergy	☐	☐	High cholesterol	☐	☐	Edema	☐	☐	Belching
☐	☐	Stomach ache/ulcer	☐	☐	Strong appetite	☐	☐	Constipation	☐	☐	Bleeding gums
☐	☐	Diarrhea	☐	☐	Weak appetite	☐	☐	Nausea	☐	☐	Low energy/fatigue
☐	☐	Loose stools	☐	☐	Change in appetite	☐	☐	Abdominal bloating	☐	☐	Blood in stools
☐	☐	Anemia	☐	☐	Sweet taste in mouth	☐	☐	Low body weight	☐	☐	Pus in stools
☐	☐	Halitosis	☐	☐	Cravings for sweets	☐	☐	Hemorrhoids	☐	☐	Rectal pain

Symptoms of **Metal** Element

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Bronchitis	☐	☐	Sore throat	☐	☐	Sinus congestion	☐	☐	Acne
☐	☐	Asthma	☐	☐	Difficulty swallowing	☐	☐	Production of phlegm	☐	☐	Rashes
☐	☐	Wheezing	☐	☐	Laryngitis/hoarse voice	☐	☐	Hay fever or allergies	☐	☐	Hives
☐	☐	Shallow breathing	☐	☐	Sinus infection	☐	☐	Pneumonia	☐	☐	Eczema
☐	☐	Cough	☐	☐	Nasal infection	☐	☐	Often feel sad	☐	☐	Psoriasis
☐	☐	Cough with blood	☐	☐	Frequent cold and flu	☐	☐	Crave pungent foods	☐	☐	Decreased ability to smell
☐	☐	Nose bleeds	☐	☐	Dry skin	☐	☐	Itching			

Using check marks please indicate if you have recently experienced any of the following:

1 check mark = occasionally 2 check marks = Regularly 3 check marks = Extreme

Mood

___ difficulty making decisions
___ lack of concentration
___ poor memory
___ lonely or depressed
___ cries often
___ hopeless outlook
___ difficulty relaxing
___ worrisome
___ frightening dreams/thoughts
___ dislike criticism
___ loses temper easily
___ annoyed easily
___ work or family problems
___ sexual difficulties

General

___ gained/lost more than 10 lbs.
___ tend to be too hot or cold (circle which one)
___ loss of appetite
___ always hungry
___ more thirsty lately
___ armpit or groin swelling
___ exhausted or fatigued
___ sleeping difficulties
___ exercise less than 3x/week
___ use sleeping pills or sedatives
___ use hard drugs
___ drive a vehicle over 25K/yr
___ desired physical help
___ considered suicide