CALM SPIRIT ACUPUNCTURE
Alexia Bennetts, B.S., L.Ac., Dipl.Ac. Robin van Maarth M.S., L.Ac. Dipl. OM
11890 West 64th Avenue, Arvada, CO 80004 (303) 467-5337

REFERRED BY______________________

PATIENT INTAKE FORM

Patient's name: ____ **Date** _______________________

Age________ **Height:** ______ **Weight:** ______ **Occupation**:__________________________

Chief Complaint: ____

____

Condition worsens w/:____

Condition improves w/:____

When did this condition begin?____

Please list any previous treatment or tests you have received for your chief complaint:

Are you presently seeing a physician for ANY ailment? Yes No

If yes, for what?

Medication/Supplements
What prescribed or over the counter, medication, herbs, vitamins, supplements are you taking currently?____

____

____

Check each you are currently using:

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Heart/blood medication	Allergy medication	Thyroid medication
Sleeping pills	Anti-depressants	Birth control pills	Hormones

Please check any of these conditions you have had any time in your lifetime:

Asthma	**Viral Hepatitis**	**Tuberculosis**	**High Blood Pressure**	**Arthritis**
Bronchitis	**Surgery**	**Epilepsy**	**Low Blood Pressure**	**Heart Condition**
Pneumonia	**Measles**	**Allergies**	**Depression**	**Colitis or Crohn's**
Cancer	**Mumps**	**Diabetes**	**Ulcer**	**Irritible Bowel**
AIDS / HIV	**Leukemia**	**Bleeding Disorder**	**Meningitis**	**Shingles**
Alcoholism	**Mono**	**Thyroid Condition**	**Herpes**	**Frostbite**
Substance Abuse		**Car Accident**	**Mental Illness**	

Patient's name:____ Date _______________________ 2

What hospitalizations, surgery, x-ray and special studies have you had?

____Year_________________
____Year_________________
____Year_________________
____Year_________________
____Year_________________

Allergies Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list

____

Family Medical History:

Does anyone in your immediate family (parents/siblings/grandparents) have major health issues? Please list

Lifestyle:

Do you exercise? What type and How often?
How much alcohol per week: ______drinks per_______ How much coffee per day: ______cups per _______

Soda? _________per____ Tobacco? ______cigarettes per _______ Recreational drugs? ______________

Emotions:

Circle those you have more frequently. Rate stress level from 0-10 with 10 being intolerable. ____________

stressed / happy / sad / depressed / frustrated / angry / relaxed / worried / cries easily /

irritable / anxious / difficulty concentrating / overwhelmed / fearful / restless / nervous

Energy:

Rate average day to day energy level from 0-10 with 10 being great.____________
Does your energy tend to be up and down?

Sleep: Hours per night ____ Time to bed_____ Time to wake ______ Waking rested – Yes / No

Temperature/ Perspiration:

Do you tend to be warmer / cooler?
Do you regularly get alternating chills and fever?
Do you tend have cold hands / feet?
Do you get night sweats or hot flashes?
Do you perspire easily or normally with exertion?

Thirst:

Do you have strong thirst/ no thirst/ recently more than usual/ thirsty @ night/ dry throat?
Do you prefer hot / cold / room temp drinks? How much water do you drink per day (# of 8 oz glasses)______

Appetite:

Do you tend to be not hungry/ very hungry/ hungry at a particular time?
Have you had weight loss / gain?
How much weight in how much time?

Diet What does your daily food intake look like:

Breakfast____

Lunch ____

Dinner____

Snacks____

After eating do you have: Fatigue Bloating Gas Belching Pain Immediate bowel movement Other

Patient's name:______________________________________ Date ______________________

Symptoms
Check for symptoms in the last 6 months. Be sure to answer questions marked with *

General
Fever/Hot often
Chills/Cold often
Easy/profuse sweat
Difficulty falling asleep
Difficulty staying asleep
Waking tired
Strong thirst
Fatigue
Night sweats
Weight gain
Weight loss
Easy bleeding
Easy bruising
***Sudden energy drop at particular time? When:**

Skin/hair
Rashes
Itchy skin
Dandruff
Itchy scalp
Dry skin/hair
Change in skin/hair texture
Ulcerations
Eczema
Hair loss
Hives
Pimples
New moles
Psoriasis
Other

***Location of skin conditions:**

Cardio
High Blood Pressure
Low Blood Pressure
Irregular heartbeat
Cold hands/feet – all day/night:
Difficulty breathing
Wheezing
Swollen hands/feet
Chest pain
Fainting
Other

H.E.E.N.T.
Dizziness
Poor vision
Blurry vision
Night blindness
Color blindness
Spots in front of your eyes
Glasses/contacts
Laser eye surgery? When:
Cataracts
Sinus congestion
Grinding teeth
Other teeth problems
Dentures
Concussion
Ringing in ears
Difficulty hearing
Nasal congestion
Nose bleeds
Facial pain
Jaw clicks
Migraine headache
Recurrent sore throat
Sores in mouth
Sores on lips/tongue
Dry mouth
***Headaches:**
Where:
When:
How often:

Respiratory
Chronic cough
Bronchitis
Pneumonia
Difficulty breathing lying down
Coughing blood

Gastro
Nausea
Vomiting
Heartburn
Constipation
Diarrhea
Black stool
Bad breath
Abdominal pain/cramps
Gas
Bloating
Belching
Indigestion
Loss of appetite
Excess appetite
Blood in stool
Mucous in stool
Foul smelling stool
Watery stool
Food in stool
Rectal pain
Rectal itching
Chronic laxative use
Hemorrhoids
Hunger soon after eating
Cravings
Other
***How many bowel movements a day? __________________**
Well formed & complete?

Difficult to pass?

Patient's name:___________________________________ **Date** _____________________

Check for symptoms in the last 6 months. Be sure to answer questions marked with *

Genitourinary
Painful urination
Blood in urine
Frequent urination
Incontinence
Urgent urination
Decrease in flow
Do you wake at night to urinate – how often _______
Genital sores
Impotence
Kidney stones
Other

Musculoskeletal
Neck pain
Frozen shoulder
Tennis/Golf elbow
Carpal tunnel
Hand pain
Chest pain
Hip pain
Restless leg
Knee pain
Foot or ankle pain
Muscle weakness
Tremors
Arthritis – where
Any other bone or muscle problem

Neurological/Psychological
Seizures
Numbness – where:

Concussion
Bad temper/irritable
Dizziness
Depression
Anxiety
Feeling stressed out
Lack of coordination
Loss of balance
Poor memory
Difficulty concentrating
Suicidal thoughts
Other

Men
Low sex drive
High sex drive
Difficulty starting erection
Difficulty maintaining erection
Discharge form penis – what color
Prostate condition

Women
Menarche – Age:
Menopause – Age:
Pregnancies:
  Live birth#
  Miscarriage#
  Abortion#
Length of cycle _________days
Length of period_________days
Bleeding between periods
Clots in menses:
  Size – Quarter / Dime
Excess flow
Scant flow
Changes in color or amount
Changes in color, amount or quality of cervical fluid/ discharge
Extreme menstrual pain
Menstrual Diarrhea/Constipation
Irregular cycle
Vaginal discharge
PMS breast distention
PMS irritability
PMS abdominal pain
PMS back pain
Low sex drive
High sex drive
Hormonal Birth Control within last 6 months? What type:

Overview
We would like to welcome you to our practice. We look forward to taking part in your healthcare whether you are here for a single visit or looking for longer term solutions. Below are a few questions that will help us understand your situation and how we can help you most effectively:

How did you find us and what caused you to make the decision to make an appointment?

What do you currently do regularly that supports your health – lifestyle habits, behaviors, practices ?

What do you love about your life at this time?

What do you currently do that you believe is self-destructive – lifestyle habits, behaviors, practices?

What do you see as potential obstacles undermining your health and ability to adhere to therapeutic protocols or recommendations?

What are your top three expectations of us?