EASTERN SCHOOL OF ACUPUNCTURE AND TRADITIONAL MEDICINE

440 Franklin Street. Ste. 550
Bloomfield, NJ 07003
Phone: 973-746-2848
Fax: 973-746-2088

HOW DID YOU HEAR ABOUT US?_____

Eastern School of Acupuncture and Traditional Medicine Student Clinic Intake Form

Intake Form Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

Date of Birth: _____ Age: _____ Email: _____

Marital Status: ☐M ☐S ☐W ☐ D Gender: M F

Occupation: _____

Level of Highest Degree: ☐ High School ☐ Some College ☐ Associate's ☐ Bachelor's ☐ Master's ☐ Professional ☐ Doctorate

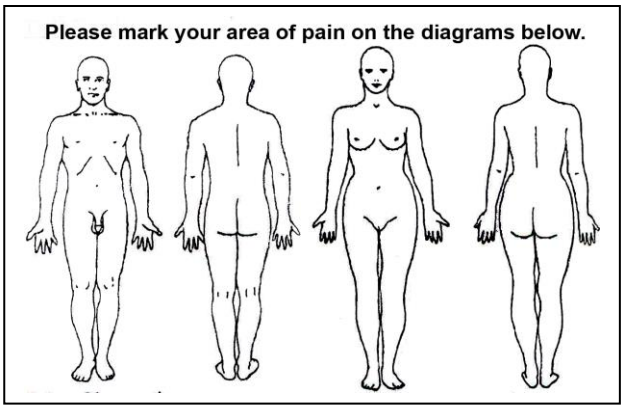
Emergency Contact's Name: _____ Phone: _____

Physician's Name: _____ Phone: _____
Physician's Diagnosis: _____
Height: _____ Weight: _____

Allergies:
_____
_____

1. Have you ever had acupuncture before? ☐ Yes ☐ No
2. Have you eaten today? ☐ Yes ☐ No
   a. If so, at what time was your last meal? _____
3. What is the problem that brought you here today? _____
4. Has there been anything that has ever been able to change your problem in any way? ☐ Yes ☐ No
   a. If yes, please describe._____
5. When did this problem first appear? _____
6. Is it constant or does it come and go? _____

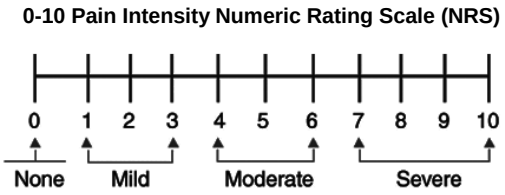
7. If applicable, does the problem ever move? (For example, pain or spasms that occur in different joints or muscles at different times) ☐ Yes ☐ No



8. Do you have a history of chronic pain? ☐ Yes ☐ No

9. Are you experiencing pain right now? ☐ Yes ☐ No

10. If yes, what number best describes your pain? _____



12. What is the frequency of the pain? ☐ Continuous ☐ Intermittent

13. What makes your pain better? Please check all that apply.

☐ Heat ☐ Pressure ☐ Movement
☐ Cold ☐ Massage ☐ Rest

Other: _____

14. Is your illness affected by seasonal changes? Please describe._____

_____

15. Are there other problems you would like addressed? _____

_____

_____

16. Date	Medications, Vitamins & Supplements you take presently	Dosage, Route and Frequency

17. Have you had any surgeries/hospitalization? If yes, what type of surgery/procedure and when did you have it done?

_____

18. History of Significant Illness:

Self: (Please include all past accidents, childhood illnesses, and the date that they occurred)

_____

_____

Siblings: _____

Mother: _____

_____

Father: _____

_____

Maternal Grandmother/Grandfather: _____

_____

Paternal Grandmother/Grandfather: _____

_____

19. Have you ever smoked? ☐ Yes ☐ No

20. If yes, do you still smoke? ☐ Yes ☐ No If no, when did you quit? _____

a. If yes, how many cigarettes do you smoke daily? _____

21. Do you drink alcohol? If yes,

b. how many glasses per week? _____

22. Describe your sleep habits:

Number of hours per night that you sleep:		Do you awake very early and are then unable to go back to sleep?	☐ Yes ☐ No
Do you have trouble falling to sleep?	☐ Yes ☐ No	Do you wake up frequently? If so when?	☐ Yes ☐ No _____

23. Describe your bowel habits: ☐ regular (Times per day: _____) ☐ constipation ☐ diarrhea

24. If you suffer from constipation,

a. do you feel better or worse immediately after moving your bowels? _____

b. how many days pass before you move your bowels? _____

25. If you suffer from diarrhea,

a. does it occur early in the morning when you first wake up? _____

b. does your rectum burn as the stool exits? _____

c. how many episodes of diarrhea do you have per day? _____

26. Do you regularly experience abdominal pain? _____

a. If yes, what makes it better? Please check all that apply.

☐ Heat	☐ Eating	☐ Rest	☐ Massage
☐ Cold	☐ Not Eating	☐ Movement	☐ Other

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

☐ Anxiety	☐ Mania
☐ Panic Attacks	☐ Mood Swings
☐ Depression	☐ Seasonal Affective Disorder

28. How would you rate your ability to concentrate/maintain focused thinking, and have clarity of thought?

Please check one choice.

☐ Excellent ☐ Good ☐ Fair ☐ Poor

29. How many times a day do you urinate per day? _____

a. Color of Urine:	☐ Clear	☐ Pale Yellow	☐ Dark Yellow
b. Volume of Urine:	☐ Scant	☐ Normal	☐ Abundant

30. How would you rate your appetite? Please check one choice.

☐ Excessive ☐ Moderate/Good ☐ Poor

31. Do you crave sweets? ☐ Yes ☐ No

a. Do you crave other foods? If yes, what type? _____

32. Do you get headaches often? ☐ Yes ☐ No

a. If yes, is the headache always in the same location? _____

Where? _____

33. Do you ever experience dizziness? ☐ Yes ☐ No

34. Are you often thirsty? ☐ Yes ☐ No

35. What temperature do you prefer your drinks? Please check one choice.

☐ Cold ☐ Room Temperature ☐ Warm

36. Do you often feel cold? ☐ Yes ☐ No

a. If yes, where? Please check all that apply.

☐ Hands / Feet ☐ Limbs ☐ Entire Body ☐ Other

37. Describe the degree to which you sweat: ☐ Very Little ☐ Average ☐ Excessive

a. Do you sweat at night? ☐ Yes ☐ No

38. Do you exercise? ☐ Yes ☐ No

a. If yes, how often? _____

b. What do you do? _____

39. How would you rate your energy level?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Other

40. Describe your diet:

a. Number of vegetable portions eaten daily: _____

b. Number of meat product portions eaten daily: _____

c. Number of dairy product portions eaten daily: _____

d. Number of caffeine containing products eaten daily: _____

e. Number of whole grain product portions eaten daily: _____

41. Have you had your lymph nodes removed? ☐ Yes ☐ No

If yes, please describe._____

42. Do you have any infectious diseases? ☐ Yes ☐ No

If yes, please list:

43. Do you have a history of drug abuse? ☐ Yes ☐ No

WOMEN ONLY

44. Is there a chance that you could be pregnant? ☐ Yes ☐ No

45. Are your menstrual cycles: ☐ Regular ☐ Irregular ☐ Early ☐ Late

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

b. How many days does your period last?

c. Age of Menarche (first menstrual cycle):

46. Is your menstrual flow: ☐ Heavy ☐ Normal ☐ Light

47. Is the blood: ☐ Normal ☐ Purplish ☐ Dark ☐ Light

48. Does your menstrual blood contain clots? ☐ Yes ☐ No

a. If yes, what color are the clots? ☐ Bright Red ☐ Dark in Color

b. Are they larger than a quarter? ☐ Yes ☐ No

49. Do you have vaginal discharge?: ☐ Clear/ ☐ White and thin ☐ Yellow and Thick

50. Do you have itching or soreness of the vagina? ☐ Yes ☐ No

51. If you generally experience mood swings, use the choices below to describe how they are around the time of your menses. Please check one. ☐ Better ☐ Worse ☐ Same ☐ Not Applicable

51. Number of pregnancies: _____ Number of miscarriages: _____ Number of abortions: _____

52. Do you have symptoms that only appear prior to your period? ☐ Yes ☐ No

If yes are they: Sore Swollen Breasts ☐ Mood Swings ☐ Headaches ☐ Bloating ☐ Anger ☐ Sadness ☐ Other ☐

Reviewed by:		
Intern's Printed Name:		Date:
Intern's Signature:		
Clinical Supervisor's Printed Name:		Date:
Clinical Supervisor's Signature:		