Welcome to Back To Wellness
Acupuncture and Nutrition Intake Form

Please note that all information is strictly confidential.

First Name: Middle Initial: Last Name:

Date of Birth: / / Age:

Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐

Address: City/State/Zip:

Home Phone: Work Phone:

Email Address: Cell Phone:

May we correspond with you (follow-up questions, etc.) via email? Yes ☐ No ☐

If not, how shall we correspond with you?

Occupation: Name of Company:

In Case of Emergency Contact:

Relationship & Phone:

Family Physician: Phone:

How did you hear about us?

Reason for Today's Visit:

What is the reason for your visit today? ____

____

How, when and where did this condition begin?

____

____

What types of treatments have you tried, if any?

____

____

How does this condition impair your daily activities?

____

____

What makes it better or worse?____

Please list your main health problems that you would like to be free of in order of importance:

1. ____
2. ____
3. ____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, Falls and Major Accidents (incl. Dates):

____

____

____

Any falls/injuries to sacrum/head/tailbone (describe):______________________________

____

Any birth trauma that you know of:____

Family History:

Health and major emotional states as a child:

____

____

List any major health issues in your family (going back to parents)_______________

____

____

Family History of Substance Abuse________Suicide__________Other trauma_______

History of Abuse: circle if applicable: physical emotional sexual other

Please list any **medications/vitamins/supplements** you are currently taking:

Medications	Reason	When &For how long

Herb/Medication **allergies** and reaction (if any):________________________________

Do you have, or have you ever had any of the following illnesses?

☐ Mental Illness	☐ Diabetes	☐ Hepatitis	☐ HIV+
☐ Seizures	☐ Cancer	☐ Heart Disease	☐ Asthma
☐ Allergies	☐ Stroke	☐ Arthritis	☐ Ulcers
☐ High Blood Pressure	☐ Venereal Disease	☐ Osteoporosis	☐ AIDS
☐ Rheumatic Fever	☐ Thyroid Problems	☐ Mononucleosis	☐ Gall Stones
☐ Herpes	☐ Kidney Stones	☐ Chronic Fatigue	☐ Parasites

☐ Other ___________________________________

Lifestyle:

How good do you feel your nutrition is? ____________________________________

Typical Breakfast: _____________________________ Lunch: ______________________________

Dinner: __________________________________ Snacks:___________________________________

Worst food in your diet?_______________ What foods do you crave?____________________

Water intake per day _____________ Caffeine(what form & how much)________________

Do you use tobacco? ____ How much?__________ Alcohol?______ How much?_________

Work: Do you enjoy your work? ☐ Yes ☐ No Hours per week working: __________

Exercise:

Do you Exercise? ☐ Yes ☐ No Number of times/ week: ___________

Type of exercise: ____

Sleep:

Do you have trouble falling asleep? ☐ Yes ☐ No

Time to bed:_________________ Time to rise: _________________

How many hours of sleep do you get per night? _____________

Are you rested in the morning? ☐ Yes ☐ No Do you wake in the night? ☐ Yes ☐ No

How is your home environment?

____

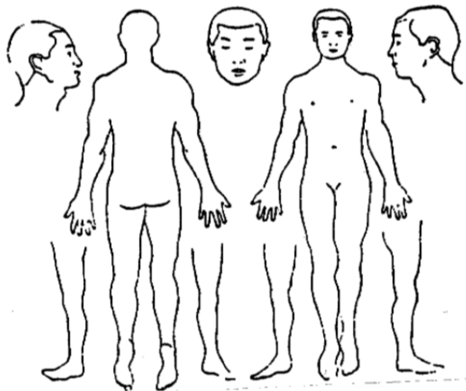
Describe any stressors occurring at this time:____

What are hobbies/activities that provide you with a sense of pleasure and accomplishment?____

What is the most negative emotion you experience?_________________________

When and Where?____

Please mark all areas of pain on the diagram:



Urination: Please circle any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty Profuse Dribbling Greater than 1x a night

Bowel Movements: Frequency: ____________ Feels complete? Yes No Painful? Yes No

Consistency: Well-formed Hard Loose Alternates

Undigested food Blood Mucus Sink Float

Men Only:

Have you been diagnosed with prostate problems? ☐ Yes ☐ No

Do you experience premature ejaculation? ☐ Yes ☐ No

Do you have problems with Impotence? ☐ Yes ☐ No

Have you been diagnosed with Infertility? ☐ Yes ☐ No

Diseases/ Disorders:

____

____

Women Only:

At what age did you get your first period: ________ Age of last menstrual cycle? ________

Are you currently using contraception? ☐ Yes ☐ No How long have you used contraception throughout your life?__________ Dates/Type:___________________________

Are you pregnant now? ☐ Yes ☐ No

How many pregnancies have you had?_______ No. of deliveries______Dates____________

Terminations:______________________ When_______________ Complications?______________

Miscarriages:______________________ When_______________ Complications? _____________

Maternal Family History of (please circle): Infertility Fibroids Endometriosis

Cancer (type)________________ Menstrual Problems PMS Menopause

Medications your mother took when she was pregnant with you (if any)_______________

Number of days from the start of one period to the start of the next: ___________________

Are your menstrual cycles spaced regularly? ☐ Yes ☐ No

Average number of days of flow: __________ Flow is: ☐ Light ☐ Normal ☐ Heavy

Color is: ☐ Pale ☐ Normal ☐ Dark ☐ Bright Red ☐ Brown

Are blood clots present? ☐ Yes ☐ No

Does your period cause you pain or cramping? ☐ Yes ☐ No

When? ☐ Before ☐ During ☐ After Period

Do you get nausea or vomiting with your period? ☐ Yes ☐ No

When? ☐ Before ☐ During ☐ After Period

Do you experience any of the following before your period each month?

☐ Water retention ☐ Breast tenderness or swelling ☐ Mental depression

☐ Irritability ☐ Food cravings ☐ Migraines ☐ Other________________

Do you ever bleed or spot between periods? ☐ Yes ☐ No

Do your bowel movements become loose at the beginning of your period? ☐ Yes ☐ No

Do you have/have you ever had:

Abnormal pap smear? ☐ Yes ☐ No When/Why?________________________________

A cervical biopsy, operation, cauterization, conization? ☐ Yes ☐ No

Venereal disease? ☐ Yes ☐ No   Chlamydial infection? ☐ Yes ☐ No

Yeast infections? ☐ Yes ☐ No   Sores on your genitals? ☐ Yes ☐ No

Uterine fibroids or polyps? ☐ Yes ☐ No   Endometriosis? ☐ Yes ☐ No

Varicose veins? ☐ Yes ☐ No   Sore heels when walking? ☐ Yes ☐ No

Painful intercourse? ☐ Yes ☐ No

Numb legs/feet when standing still? ☐ Yes ☐ No

Pelvic inflammatory disease? ☐ Yes ☐ No   Difficulty experiencing orgasm? ☐ Yes ☐ No

Were you treated for it? ☐ Yes ☐ No   How____________________________

Date of last pap smear? ____________________

Have you been diagnosed with pelvic adhesions? ☐ Yes ☐ No

Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you experienced menopause? ☐ Yes ☐ No   When? ____________________

If you are experiencing menopausal symptoms, please describe: ____________________

____

Body Systems Review:

0 = never   1 = rarely   2 = occasionally   3 = frequently   4 = always

Rating	Symptom	Rating	Symptom
0 1 2 3 4	low appetite	0 1 2 3 4	ravenous appetite
0 1 2 3 4	loose stools	0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	mouth sores	0 1 2 3 4	fatigue after eating
0 1 2 3 4	abdominal gas/bloating after food	0 1 2 3 4	bruise easily
0 1 2 3 4	gums (bleeding/swollen)	0 1 2 3 4	thirst
0 1 2 3 4	organ prolapsed (diagnosed)	0 1 2 3 4	belching or vomiting

Rating	Symptom	Rating	Symptom
0 1 2 3 4	spontaneous sweat	0 1 2 3 4	fatigue
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	shortness of breath
0 1 2 3 4	general weakness	0 1 2 3 4	cough
0 1 2 3 4	dry nose/mouth/skin/throat	0 1 2 3 4	nasal discharge
0 1 2 3 4	feel worse after exercise	0 1 2 3 4	sinus congestion

Rating	Symptom	Rating	Symptom
0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	feel cold (in core)
0 1 2 3 4	low back pain	0 1 2 3 4	cold hands &/or feet
0 1 2 3 4	frequent urination	0 1 2 3 4	urinary incontinence
0 1 2 3 4	early morning diarrhea	0 1 2 3 4	hearing loss
yes no	impaired memory	0 1 2 3 4	edema
high normal low	libido	yes no	hair loss

0	1	2	3	4	muscle spasms/twitches	0	1	2	3	4	irritable
0	1	2	3	4	feel better after exercise	0	1	2	3	4	numb extremities
0	1	2	3	4	tight feeling in chest	0	1	2	3	4	dry eyes
0	1	2	3	4	alternating diarrhea/constipation	0	1	2	3	4	ear ringing
0	1	2	3	4	symptoms worse with stress	0	1	2	3	4	anger easily
0	1	2	3	4	neck/shoulder tension	0	1	2	3	4	red eyes

0	1	2	3	4	feel heart beating	0	1	2	3	4	chest pain
0	1	2	3	4	insomnia	0	1	2	3	4	disturbing dreams
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4	headaches
0	1	2	3	4	anxiety	0	1	2	3	4	restlessness
0	1	2	3	4	chest pain traveling to shoulder						

high	normal	low	overall body temperature
high	normal	low	overall energy level

0	1	2	3	4	see floaters in eyes	0	1	2	3	4	foggy thinking
0	1	2	3	4	heat in palms or soles	0	1	2	3	4	dizzy upon standing
0	1	2	3	4	feeling of heaviness	0	1	2	3	4	nausea
0	1	2	3	4	afternoon fever	0	1	2	3	4	night sweats
0	1	2	3	4	enlarged lymph nodes	0	1	2	3	4	cloudy urine
0	1	2	3	4	face flushes						

Adrenal Stress Questions:

	Duration (Years)		
Excessive Fatigue	☐1/2	☐1	☐2
Dry & Thin Skin	☐1/2	☐1	☐2
Nervous/Irritability	☐1/2	☐1	☐2
Low body temperature	☐1/2	☐1	☐2
Premenstrual tension	☐1/2	☐1	☐2
Inability to concentrate	☐1/2	☐1	☐2
Mental depression	☐1/2	☐1	☐2
Food allergies & sensitivities	☐1/2	☐1	☐2
Craving for sweets	☐1/2	☐1	☐2
Headaches	☐1/2	☐1	☐2
Alcohol intolerance	☐1/2	☐1	☐2
Poor memory	☐1/2	☐1	☐2
Heart palpitations	☐1/2	☐1	☐2

Do you have chronic pain? ☐Yes ☐No

Check the box of each life event in this list that happened in the last twelve months.

______ Death of spouse
______ Divorce
______ Marital separation
______ Death of close family member
______ Personal injury or illness
______ Marriage
______ Marital reconciliation
______ Laid off from work
______ Retirement
______ Change in family member's health
______ Foreclosure of mortgage or loan
______ Change in work responsibilities
______ Starting or finishing school

______ Change in financial status
______ Death of close friend
______ Change in line of work
______ Change in # of marital arguments
______ Mortgage or loan over $10K
______ Son or daughter leaving home
______ Spouse begins or stops work
______ Sex difficulties
______ Addition to family
______ Trouble with boss
______ Change in work hours and/or conditions
______ Change in residence
______ Change in sleeping habits
______ Change in eating habits