Print Form

RED DRAGON WELLNESS

CHIROPRACTIC — ACUPUNCTURE — NUTRITION

Acupuncture Intake

Name _____

Address _____

City _____ Zip code _____ Preferred phone _____

☐ Male ☐ Female Age _____ Birth Date _____ E-mail _____

Who may we thank for referring you? _____

Employment Information

Patient employed by _____ Occupation _____

Business address _____

Business phone _____

Emergency Information

Notify in case of emergency _____ Emergency phone _____

Reason For Visit

Have you ever seen a acupuncturist? ☐ Yes ☐ No If yes, when and why? _____

Your reason for this visit: _____

Please describe your current symptoms: _____

_____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Energy Levels

Please check the following if they presently apply to you.

- ☐ Fatigued, or fatigue easily
- ☐ Need to take nap
- ☐ Generally feel cold
- ☐ Cold feet
- ☐ Cold hands
- ☐ Wake up sweating during the night

Appetite and Digestion

- ☐ Appetite altered recently
- ☐ Poor appetite
- ☐ Frequent gas

What percentage of your diet is the following;

Animal protein: _____ Vegetables: _____ Carbohydrates: _____ Fruit: _____ Sweets: _____ Snacks: _____

List any suspected or known food allergies: _____

Thirst and Dryness

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- ☐ Excessive thirst
- ☐ Dry eyes
- ☐ Dry nose or lips
- ☐ Dry skin
- ☐ Dry hair

How many glasses of water or fluids do you drink daily: _____

Stools

- ☐ Normal (daily with the same shape and size)
- ☐ Unusually hard
- ☐ Unusually loose
- ☐ Erratic in form (sometimes hard, sometimes loose)
- ☐ Bowel movements less than 5 times per week (constipation)
- ☐ Blood or pus in your stool
- ☐ Hemorrhoids

Urine

- ☐ Unusually scanty and dark
- ☐ Unusually profuse and clear
- ☐ Wake more than once at night to urinate
- ☐ Dribbling of urine
- ☐ Urgency to urinate
- ☐ Burning with urination

Sleep

☐ Trouble falling asleep ☐ Trouble staying asleep

Emotions

Do you experience excessive:

Anger: ____ Fear: ____ Worry: ____ Sadness: ____ Depression: ____ Anxiety: ____

Do you experience mood swings? _____

Are they related to eating or not eating? _____

Do you take mood regulating prescription medications? _____

Muscular Skeletal

- ☐ Chronic or occasional backache or neck ache
- ☐ Chronic or occasional joint pain
- ☐ Muscles ache or cramp

Accidents

Please list all major accidents, including fractures, deep cuts, serious sprains, etc. Please indicate all head injuries. Include dates or age: _____

_____

_____

Surgeries

Describe the reason, age and any consequential outcome: _____

Exercise

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What do you do for exercise? How often? _____

Disease History

Do your parents have any unusual health problems?
if they died, state cause of death and age of death. _____

Father: _____

Mother: _____

During your mother's pregnancy with you did she (if you know):

☐ Drink alcohol ☐ Smoke cigarettes ☐ Take medications ☐ Suffer serious illness ☐ Suffer emotionally or physically

Please check if you have or have had any of the following:

Past:	Now:	
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bruising
☐	☐	Cancer
☐	☐	Candida
☐	☐	Cholesterol, high
☐	☐	Chronic fatigue
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Edema
☐	☐	Epilepsy

Past:	Now:	
☐	☐	Frequent colds
☐	☐	Gallstones
☐	☐	Hay fever allergies
☐	☐	Headaches
☐	☐	Heart murmur
☐	☐	Heart palpitations
☐	☐	Hepatitis: Type____
☐	☐	Herpes
☐	☐	Hypertension
☐	☐	Hypotension
☐	☐	Kidney stones
☐	☐	Low sex drive

Past:	Now:	
☐	☐	Mental illness
☐	☐	Mononucleosis
☐	☐	Nose bleeds
☐	☐	Numbness
☐	☐	Prostate problems
☐	☐	Sciatic pain
☐	☐	Skin problems
☐	☐	TMJ
☐	☐	Ulcers
☐	☐	Parasites

Any other serious illness, injuries or complaint? _____

Please list any medications (including pain killers),
vitamins or herbal supplements you are taking: _____

_____

_____

_____

_____

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Women Only

- ☐ Amenorrhea (long time spans without a period)
- ☐ Chronic vaginal or yeast infections
- ☐ Endometriosis
- ☐ Irregular Periods
- ☐ Menstrual cramps
- ☐ Miscarriage
- ☐ Ovarian cyst
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Uterine fibroids

Birth control method (past or present); number of years of usage: _____

Menstrual history

☐ Pregnant ☐ Menopausal disorder ☐ Completed menopause ☐ Hysterectomy

If you are still having your periods:

How many days between your periods? _____

How many days does your period last? _____

- ☐ Regular Period
- ☐ Ovulation painful
- ☐ Bleed excessively or to little
- ☐ Discharge clots

Do you get headaches during menstruation or ovulation? _____

Do you suffer from premenstrual syndrome (PMS)? If yes, please indicate: _____

☐ Breast distention ☐ Irritability ☐ Headache ☐ Water retention

How many days before your period do the PMS symptoms begin? _____

Pregnancy history

How many times have you been pregnant? _____

Did you have difficulty getting pregnant? _____

Did you have difficulty following childbirth? _____

The present ages and gender of your living children: _____

Men Only

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Prostate Problems
- ☐ Wake up at night to urinate

Consent for Treatment

I voluntarily consent to the rendering of care including treatment and performance of diagnostic procedures.

I understand that there are minor risks associated with acupuncture treatment, including but not limited to slight bleeding and or bruising of the skin. I understand that the risk of infection is negligible when using a single use, disposable needle. Cupping may produce occasional bruising.

I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

Signature of patient _____ Current Date _____

Signature of parent/guardian if patient is a minor _____ Current Date _____