

Angela Bell Acupuncture
186 Alewife Brook Parkway, Suite 302
Cambridge, MA 02138

INITIAL INTAKE FORM

First Name: _____ MI: _____ Last Name: _____ Date _____

Address _____

City: _____ State: _____ Zip: _____

Phone: day _____ Eve _____ Cell: _____

Date of Birth ____ / ____ / ____

I will never sell or transfer your information to third parties. I would like to send you our newsletter or information by email. May I? () Yes () No May I by mail? () Yes () No

Email: _____

Gender: Male Female

Emergency Contact: _____ Contact Phone: _____

Primary Physician _____ Physician's Phone: _____

Referral Information (How did you hear about us?):

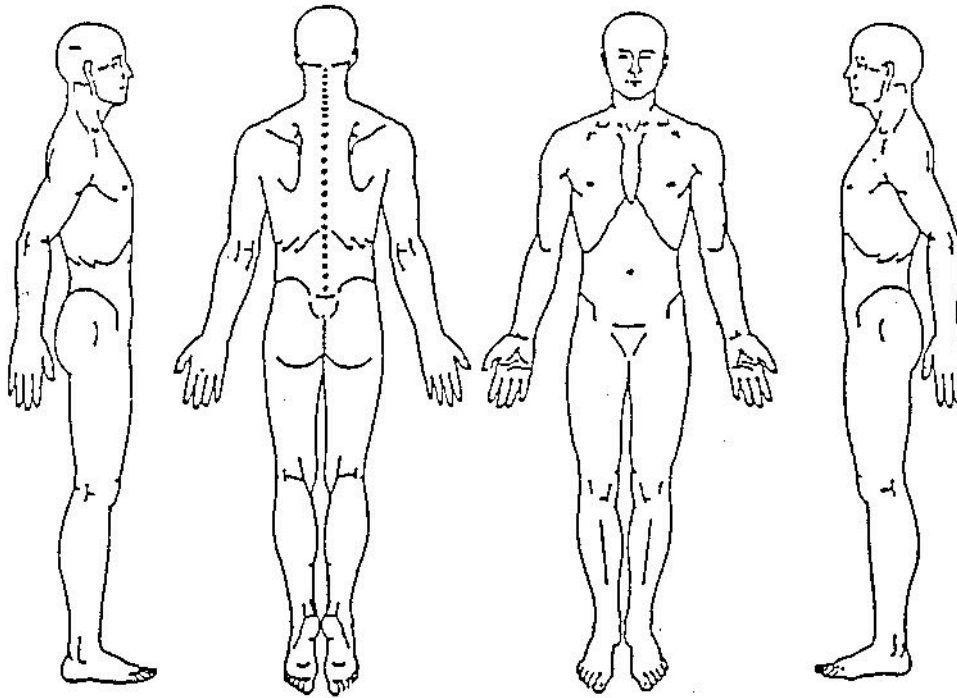
CURRENT HEALTH

What are the main symptoms/problems you seek treatment for, and how long have you had them?

Diagnoses you've been given by physicians: _____

Have you had any treatment, surgery, or hospitalization for your main complaint? _____

Please indicate any painful or distressed areas by circling the area.



WESTERN MEDICAL DIAGNOSIS

Please check off any Western Diagnosis you have now or have had in the past:

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke/heart attack | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Epilepsy/ seizures | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Allergies to metal |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chronic fatigue syndrome |
| <input type="checkbox"/> Cancer: what type _____ | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> mental health issues: what type _____ | | |

HIV/AIDS Hepatitis B Hepatitis C TB

Allergies: what drugs or substances (plant, animal, environmental) _____

DIAGNOSTIC QUESTIONS

Please indicate all symptoms below that you have experienced **within the past 30 days**.

Please circle according to the severity of your symptoms

L=Light M=Medium S=Strong

If you do not have the symptom, do not circle anything.

HEAD, EYES, EARS, NOSE, THROAT

L M S sinus problems	L M S nose bleeds	L M S dry mouth
L M S difficulty swallowing	L M S sore throat/mouth	L M S thrush/leukoplakia
L M S headaches	L M S dental/gum	L M S thirst
L M S ear/hearing problems	L M S vision problems	L M S dizziness
L M S sneezing/runny nose	L M S other (specify) _____	

RESPIRATORY

L M S shortness of breath	L M S pain w/deep breath	L M S phlegm
L M S blood in sputum	L M S wheezing	L M S cough
L M S bronchitis	L M S frequent colds	L M S chest pain
L M S other (specify) _____		

GASTROINTESTINAL

L M S loss of appetite	L M S abdominal cramps	L M S nausea
L M S gas/bloating	L M S constipation	L M S diarrhea
L M S weight loss	L M S hemorrhoids	L M S vomiting
L M S heartburn	L M S other, specify: _____	
L M S jaundice	_____	

CARDIOVASCULAR

L M S low blood pressure	L M S high blood pressure	L M S palpitations
L M S other, specify _____		

GENITO-URINARY

L M S frequent urination	L M S night urination	L M S impotence
L M S low sex drive	L M S pain	L M S edema
L M S genital sores	L M S genital warts	
L M S other, specify _____		

MUSCULAR/SKELETAL

L M S muscle/joint pain	L M S back pain	L M S weakness
L M S pain, tingling or numbness in arms, legs, fingers, toes/ neuropathy		
L M S stiff neck/shoulders	L M S other, specify _____	

NEUROLOGICAL/PSYCHOLOGICAL

L M S depression L M S anxiety L M S fear
L M S irritability/anger L M S disorientation L M S forgetfulness
L M S tremors L M S insomnia L M S seizures
L M S poor concentration L M S bipolar
L M S other, specify _____

SKIN/HAIR/NAILS

L M S itchy/painful rashes L M S fungus L M S shingles
L M S psoriasis/eczema L M S mole changes L M S cold sores
L M S new KS L M S hair loss L M S acne
L M S bleed/bruise easily L M S other _____

OTHER SYMPTOMS

L M S fever over 100 L M S night sweats L M S fatigue
L M S swollen lymph nodes L M S chills L M S day sweats
L M S glucose intolerance
L M S other _____

GYNECOLOGICAL/OBSTETRICS (*Women Only*)

L M S yeast infections L M S menstrual cramps L M S clots
L M S pelvic infections L M S spotting L M S PMS
L M S mid-cycle pain L M S irregular periods L M S no periods
L M S vaginal discharge L M S vaginal pain/itching L M S hot flashes
L M S Other _____

Menstrual Info: _____ days bleeding _____ day cycle date last period _____

Please describe in more detail any menstrual problems you are experiencing: _____

Do you take Hormone Replacement Therapy? Yes No

Are you pregnant? Yes No Unknown

Please alert your practitioner if you become pregnant. Your treatment will be modified to support a healthy pregnancy.

Are you in menopause? Yes No Unknown

How many pregnancies have you had? _____ Cesareans? _____

Date last pap smear _____ NORMAL ABNORMAL

Last breast exam _____ NORMAL ABNORMAL

WESTERN MEDICATIONS

Please list below all of the medications/supplements/herbs you currently take:

I do not take any Western medications Supplements Herbs

Medication/Supplement/Herb Used to treat Side-Effects Experienced

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____

Client Signature: _____ **Date:** _____