RENÉE HAHN ACUPUNCTURE and CRANIOSACRAL THERAPY INTAKE

Name_____Date_____

Address_____City_____State____Zip Code_____

primary phone #_____secondary phone #_____

Email address_____

Age_____Date and place of birth_____

Occupation_____

Current health care provider(s) (MDs, NDs, etc.)_____

Emergency name & phone_____Relationship_____

How did you hear about us? _____

What complaint or issue brings you to me? Please state your present complaint, injury or illness with a brief history and development (or attach a narrative):

_____

_____

_____

_____

Other problems you want to work on_____

_____

Is this the first time you've had acupuncture?_____Craniosacral therapy?_____

SYMPTOMS: Check symptoms you currently have or have had in the past year.

GENERAL

{ } Fatigue
{ } Insomnia
{ } Disturbed Sleep
{ } Frequent dreams/nightmares
{ } Intolerance to cold
{ } Intolerance to heat
{ } Weight loss
{ } Weight gain
{ } Fever
{ } Chills
{ } Unusual thirst
{ } Abdominal bloating/gas
{ } Swollen glands
{ } Belching
{ } Edema/swelling
{ } Other:

SKIN

{ } Rashes
{ } Hives
{ } Night sweats
{ } Excessive daytime sweating
{ } Dry skin
{ } Bruise easily
{ } Changes in mole or lump
{ } Unusual bleeding
{ } Other:

MUSCLES AND JOINTS

Pain, weakness, numbness in:
{ } Arms
{ } Legs
{ } Hands
{ } Feet
{ } Hips
{ } Shoulders
{ } Neck
{ } Back
{ } Muscle cramps
{ } Swollen joints
{ } Other:

NERVOUS SYSTEM

{ } Dizziness
{ } Fainting
{ } Paralysis
{ } Tremors
{ } Poor balance
{ } Seizures { } Other:

EYES & EARS

{ } Failing vision
{ } Blurred vision
{ } Visual spots
{ } Night blindness
{ } Eye pain/swelling
{ } Ringing in ears
{ } Decreased hearing
{ } Ear pain
{ } Ear discharge
{ } Other:

NOSE, THROAT, MOUTH

{ } Nosebleeds
{ } Unusual nasal discharge
{ } Frequent sneezing
{ } Change in sense of taste
{ } Sore throat
{ } Hoarseness
{ } Difficulty in swallowing
{ } Change in sense of taste
{ } Tooth or gum pain
{ } Mouth or tongue ulcers
{ } Other:

HEART & LUNGS

{ } Palpitations
{ } Chest pain or tightness
{ } Rapid heartbeat
{ } Irregular heartbeat
{ } Swelling of ankles
{ } Coughing up blood
{ } Excessive phlegm
{ } Persistent cough
{ } Shortness of breath
{ } Asthma/wheezing
{ } Frequent colds/flu
{ } Other:

MENTAL/EMOTIONAL

{ } Difficulty concentrating
{ } Poor memory
{ } Anxiety/worry
{ } Depression
{ } Irritability
{ } Excessive anger/rage
{ } Fearfulness
{ } Unusual stress
{ } Other:

HEAD & NECK

{ } Persistent headaches
{ } Stiff neck
{ } Jaw pain/TMJ
{ } Migraines { } Grinding of teeth { } Other:

DIGESTIVE SYSTEM

{ } Nausea
{ } Vomiting
{ } Vomiting of blood
{ } Diarrhea
{ } Constipation
{ } Bloody/black stool
{ } Stomach pain
{ } Abdominal pain
{ } Poor appetite
{ } Excessive hunger
{ } Indigestion/heartburn
{ } Hemorrhoids
{ } Other:

URINARY/GENITAL

{ } Painful urination
{ } Difficult urination
{ } Freq. daytime urination
{ } Freq. night urination
{ } Incontinence
{ } Bed-wetting
{ } Dark or cloudy urine
{ } Blood in urine
{ } Genital pain or itching
{ } Genital discharge
{ } Genital lesions
{ } Painful intercourse
{ } Low sexual energy
{ } Excessive sexual energy
{ } Other:

MALE

{ } Impotence
{ } Weak urinary stream
{ } Lump in testicles
{ } Premature ejaculation
{ } Seminal emission
{ } Other:

FEMALE

{ } Irregular periods
{ } Painful periods
{ } PMS
{ } Abnormal PAP smears
{ } Bleeding between periods
{ } Menopausal symptoms
{ } Breast lump
{ } Vaginal pain
{ } Other:

CONDITIONS: Check conditions you currently have or have ever had in the past.

{ } HIV/AIDS	{ } Diabetes	{ } High Cholesterol	{ } Prostate problems
{ } Alcoholism	{ } Eczema	{ } Intestinal Disorder	{ } Psychiatric care
{ } Allergies	{ } Emphysema	{ } Kidney Disease	{ } Rheumatic Fever
{ } Anemia	{ } Epilepsy	{ } Liver Disease	{ } Scarlett fever
{ } Anorexia	{ } Gallbladder problem	{ } Lupus	{ } Stroke
{ } Arthritis	{ } German measles	{ } Measles	{ } Stomach Disorder
{ } Asthma	{ } Glaucoma	{ } Migraines	{ } Thyroid Disorder
{ } Bleeding Disorder	{ } Goiter	{ } Miscarriage	{ } Tuberculosis
{ } Bronchitis	{ } Gout	{ } Mononucleosis	{ } Ulcers
{ } Bulimia	{ } Heart Disease	{ } Multiple Sclerosis	{ } Urinary Tract Infection
{ } Cancer	{ } Hepatitis (A, B, C)	{ } Mumps	{ } Vaginal Infection
{ } Cataracts	{ } Hernia	{ } Pacemaker	{ } Venereal Disease
{ } Chemical Dependency	{ } Herpes	{ } Pneumonia	{ } Post traumatic stress
{ } Chicken Pox	{ } High Blood Pressure	{ } Polio	{ } Other:

FAMILY HISTORY: Please fill in health information about your family.

RELATION Age: State of health: Cause of death, if deceased :

Mother_____

Father_____

Sisters_____

_____

Brothers_____

_____

Check if your blood relations had any of the following:

Disease: Relation to you:

{ } Arthritis_____

{ } Asthma, hayfever_____

{ } Cancer (what type?)_____

{ } Alcohol/chemical dependency_____

{ } Diabetes (what type?)_____

{ } Heart disease, stroke_____

{ } High blood pressure_____

{ } Kidney disease_____

{ } Tuberculosis_____

{ } Other:_____

SURGERIES/HOSPITALIZATIONS:

Year: Hospital: Reason & Outcome:

_____

_____

PREGNANCY HISTORY:

Year of birth: Sex of birth: Complications, if any:

_____

ACCIDENTS/FALLS/CONCUSSIONS: List any car, bike, sports accidents and/or falls.

Year: What happened? Did you pass out?

_____

_____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? { } YES { } NO

If yes, please give approximate dates and circumstances:

Current medications/drugs/herbs/vitamins, etc. you are taking:

prescription medications _____ over-the-counter medications _____ herbs,vitamins,supplements _____

_____ _____ _____

_____ _____ _____

HISTORY OF ANTIBIOTIC USE: Please describe frequency and duration of use in lifetime IF MORE THAN ONE WEEK DURATION/ONCE EVERY TWO YEARS:_____

DO YOU HAVE ANY AMALGAM DENTAL FILLINGS (MERCURY/METAL)?_____

ALLERGIES: List any medications or other substances that you are allergic to.

_____

HEALTH HABITS: Check which substances you use and describe how often you use.

substance How much do you use and how often?

COLA_____

ALCOHOL_____

TOBACCO_____

MARIJUANA_____

COCAINE_____

CRYSTAL METH_____

OTHER_____

EXERCISE: Do you exercise regularly? { } Yes { } No

If yes, describe what type of activity and how often:

_____

DIET: Please describe your average daily diet:

Morning: Noon/afternoon: Evening:

_____ _____ _____

_____ _____ _____

_____ _____ _____

# of caffeinated beverages/day: _____type (tea, coffee, etc.)_____

WHAT IS THE GENERAL STRESS LEVEL IN YOUR LIFE CURRENTLY?_____

IF APPLICABLE, PLEASE FILL OUT:

Date of last menstrual period:_____ Date of last PAP smear:_____

Number of days between periods_____ Birth control? What type?_____

Date of last mammogram:_____ Are you pregnant? { } Yes { } No

Number of children:_____ Date of menopause:_____

Changes in body/emotions prior to period:_____

PLEASE SHARE ANY OTHER PROBLEMS/HEALTH ISSUES YOU WOULD LIKE TO DISCUSS:

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my acupuncturist responsible for any errors or omissions that I may have made in the completion of this form.

I also understand the cancellation policy: I must provide 24 hours notice if I wish to cancel or reschedule an appointment, or I will be charged for that appointment. By signing below, I am also confirming that I understand the cancellation policy of Renée Hahn Acupuncture and Craniosacral Therapy.

_____

Patient Signature Date

_____

Reviewed by Date