

# Kenneth C. Greep L.Ac.

## Acupuncture and Herbal Medicine

### PATIENT INTAKE FORM

Thank you for choosing Kenneth C. Greep L.Ac.. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask.

Full Name:		Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Date:
Date of Birth:	Age:	Occupation:	
Main Phone #:		Other Phone #:	
Email Address:		May we contact you by email? <input type="checkbox"/> Y <input type="checkbox"/> N	
Address: Street:		City:	State: Zip:
Do you live alone?			
Family physician:		Chiropractor:	
Have you ever had acupuncture before? <input type="checkbox"/> Y <input type="checkbox"/> N			
How did you hear about us?			
Emergency Contact:		Phone #:	Relation:

**Main problem(s):** \_\_\_\_\_

What diagnosis, if any, have you received for this problem? \_\_\_\_\_

When did this problem begin? \_\_\_\_\_ What are the causes of this problem? \_\_\_\_\_

How does this problem interfere with daily activities (work, sleep, sex, etc.)? \_\_\_\_\_

\_\_\_\_\_

What kind of treatments have you tried? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_ What makes it better? \_\_\_\_\_

Is there anyone in your family with the same/similar problems? \_\_\_\_\_

Remarks or additional information: \_\_\_\_\_

#### Medical History:

DIAGNOSIS	SELF	FAMILY	DIAGNOSIS	SELF	FAMILY	DIAGNOSIS	SELF	FAMILY
Cancer			Heart Disease			High Blood Pressure		
Diabetes			Digestive problems			Emotional Disorders		
Hepatitis			Venereal Disease			Anemia		
Thyroid Disease			Alcoholism			Stroke		
Seizures			Depression/Anxiety			Addiction		
Arthritis			Tuberculosis			Auto Immune disease		
Breathing problem			High Cholesterol			Other:		

Other: \_\_\_\_\_

\_\_\_\_\_

**Surgeries:** \_\_\_\_\_ **Hospitalization:** \_\_\_\_\_

**Significant trauma:** (auto accidents, sports injuries, etc) \_\_\_\_\_

**Allergies:** (drugs, chemicals, foods, environmental, pollens, molds, etc.): \_\_\_\_\_

**Medicines and Supplements:** (taken within the last two months including vitamins, OTC drugs, herbs, etc, along with their dosages): \_\_\_\_\_

**Personal:** Current Weight \_\_\_\_\_ Weight one year ago \_\_\_\_\_ Desired Weight \_\_\_\_\_  
Maximum weight ever and year \_\_\_\_\_ Height \_\_\_\_\_

**Habits:** Do you smoke?  Y  N If yes, what? \_\_\_\_\_ How many per day? \_\_\_\_\_ Since when? \_\_\_\_\_

Please describe any use of drugs for non-medical purposes: \_\_\_\_\_

Do you exercise regularly?  Y  N Please describe: \_\_\_\_\_

How many hours do you generally sleep? \_\_\_\_\_ What time do you go to bed? \_\_\_\_\_

How many times do you wake in the night? \_\_\_\_\_ What wakes you? \_\_\_\_\_

Do you feel rested in the morning?  Y  N

Comments: \_\_\_\_\_

**Diet:** Please describe your average daily diet, while being as specific as possible:

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

Snacks: \_\_\_\_\_

Do you drink coffee?  Y  N Cups per day? \_\_\_\_\_ Comments: \_\_\_\_\_

Do you drink sodas?  Y  N How many per day? \_\_\_\_\_ Comments: \_\_\_\_\_

Do you drink alcoholic beverages:  Y  N How many per day? \_\_\_\_\_ Comments: \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

Are you a vegetarian?  Y  N  Yes, but not so strict  Yes, but I am vegan  Yes, but I eat only raw foods

Do you eat a lot of spicy foods?  Y  N

Additional comments on your diet: \_\_\_\_\_

**Please check if you have had (in the last 3 months) any of the following diseases or conditions:**

**General:**

- |  |   |
|--|---|
| <input type="checkbox"/> Low energy                | <input type="checkbox"/> Night Sweats       |
| <input type="checkbox"/> Spontaneous sweating      | <input type="checkbox"/> Lack of Sweating   |
| <input type="checkbox"/> Hot/cold body temperature | <input type="checkbox"/> Weight gain        |
| <input type="checkbox"/> Excessive thirst          | <input type="checkbox"/> Weight Loss        |
| <input type="checkbox"/> Chills/Fever              | <input type="checkbox"/> Cravings           |
| <input type="checkbox"/> Aversion to heat or cold  | <input type="checkbox"/> Tremors            |
| <input type="checkbox"/> Cold hands or feet        | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Sweaty palms or feet      | <input type="checkbox"/> Dizziness          |
| <input type="checkbox"/> Hot flashes               | <input type="checkbox"/> Poor Balance       |

**Skin & Hair:**

- Rashes
- Ulcerations
- Hives
- Excessive thirst
- Itching
- Eczema
- Slow wound healing
- Acne or Pimples
- Recent Moles
- Purpura
- Dry skin
- Loss of Hair
- Change in hair texture
- Dandruff
- Others:
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  - 
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**Respiratory:**

- Cough
- Coughing Blood
- Wheezing
- Phlegm What color?
- Shortness of breath
- Difficult breathing
- Bronchitis
- Pneumonia
- Chest pain

**Allergies:**

- Mold
- Cedar
- Oak
- Elm
- Dust
- Dander
- Other:
  -

**Head, Eyes, Ears, Nose, Throat:**

- Dizziness  Vertigo  Poor balance
- Concussions  Seizures  Epilepsy
- Migraines  Frequent Headaches
- Jaw pain  TMJ
- Eye strain  Eye pain  Dry eyes  Tearing
- Wears glasses  Uses reading glasses only
- Color blindness  Night blindness
- Cataracts  Glaucoma  Blurry vision
- Spots in front of eyes
- Ringing in ears  Earache  Impaired hearing
- Sinus problems
- Nasal obstruction
- Runny nose  Sneezing
- Nose bleed
- Loss of smell
- Teeth problems
- Mouth ulcers
- Tongue sores
- Bad breath
- Bleeding gums
- Dry mouth
- Oral thrush
- Recurrent sore throat
- Hoarseness
- Difficulty swallowing
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**Gastrointestinal:**

- Nausea  Vomiting  Belching
- Gas & bloating  Low Appetite  Huge Appetite
- Diarrhea  Constipation  Black stools
- Blood in stools  Hemorrhoids  Rectal pain
- Stomach ulcer  Reflux/Heartburn  Gallstones
- Stomach pain/cramping  Indigestion
- Hypoglycemia  Parasites
- Bowel movements: Frequency: \_\_\_\_\_ Color: \_\_\_\_\_
- Odor: \_\_\_\_\_  Formed  Loose  Dry

**Cardiovascular**

- High blood pressure  Low blood pressure
- Chest pain  Palpitation  Fainting
- Irregular heartbeat  Rapid heartbeat
- Poor circulation  Blood clots
- Varicose veins  Swelling of ankles
- High cholesterol
- Other:
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**Female**

- May be pregnant?  Peri-menopausal  Hot flashes
- Menopausal  Post-menopausal  Hysterectomy
- Chronic vaginal infections  Endometriosis
- Vaginal discharge  Ovarian cysts  PCOS
- Uterine Fibroids  Uterine prolapse  PMS
- Irregular periods  Heavy periods  Scanty periods
- Clots  Breast tenderness  Breast lumps
- Menstrual cramping  Fertility problems
- Period lasts \_\_\_\_\_ days. \_\_\_\_\_ Days between periods.

**Male:**

- Prostate problems  Discharge
- Erectile dysfunction  Ejaculation problems
- Testicular pain/swelling  Nocturnal emission
- Fertility problems
- Other:
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**Genito-urinary:**

- Painful urination  Freq. urination
- Blood in urine  Urgency
- Incontinence  Dribbling
- Pause of flow  Kidney stones
- Cloudy urine  Profuse urine
- Dilute urine  Scanty urine
- Genital pain  Genital itching
- Genital rashes  STD
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**Emotional/Mental/Psychological**

- Insomnia  Nervousness
- Anxiety  Depression
- Mood swings  Irritability
- Angry often  Worry
- Poor memory  Poor concentration
- Restless mind  Terrors
- Fear  Sadness  Crying
- History of abuse
- Any diagnosis: \_\_\_\_\_

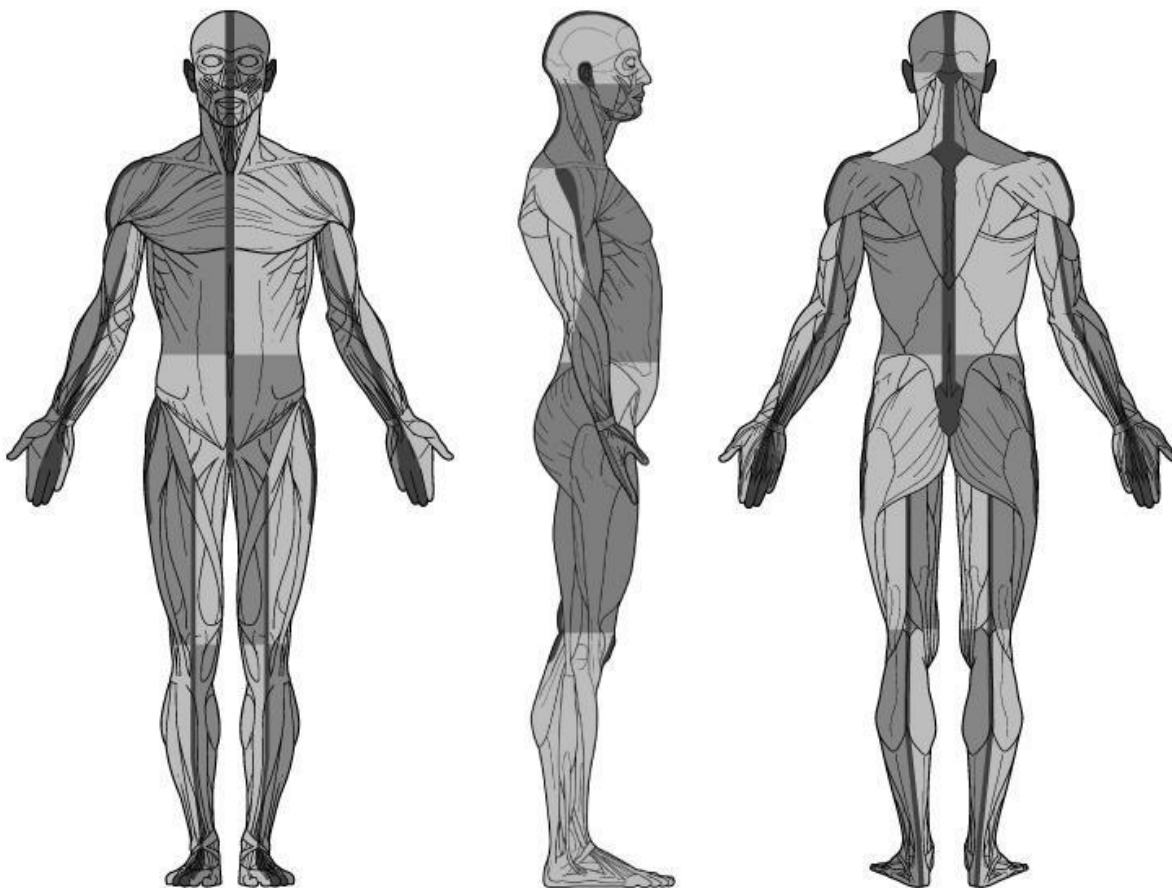
- Number of pregnancies? \_\_\_\_\_
- Number of miscarriages? \_\_\_\_\_
- Number of abortions? \_\_\_\_\_
- Number of births? \_\_\_\_\_  
\_\_\_\_\_ vaginal \_\_\_\_\_ cesarean
- Other:
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**Musculoskeletal:**

Pain/Weakness/Numbness

- Arms  Feet  Hands  Joints  Legs  Hips  Neck
- Shoulders  Back
  
- Difficulty walking  Swelling of hands/feet
- Muscle pain  Muscle injury  Paralysis

**Please indicate painful or distressed areas:**



**I have completed this form correctly and to the best of my knowledge:**

**Signature:** \_\_\_\_\_

- Adult patient  Parent or Guardian  Spouse