INTAKE AND HISTORY

Date _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Name _____ Date of birth _____ Age _____

please indicate preferred ways to contact you

Address (Street) _____ Home phone _____

City/State/Zip _____ Cell phone _____

Employer _____ Work phone _____

Type of work/title _____ Email _____

Referred by (or where did you hear of us?) _____ Employer/phone _____

Parent/Guardian (if patient is ~~a minor~~) _____ Physician name/~~phone~~ _____

Partner's name _____ Marital status _____

In case of Emergency notify: Name/Phone _____

Reason for present visit _____

_____

Have you had any of the following illnesses?

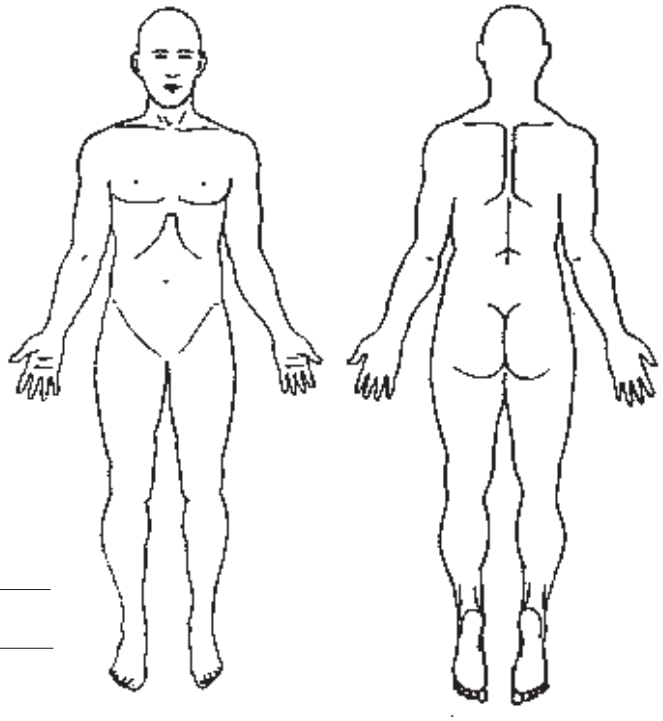
- ☐ Rheumatic Fever
- ☐ Angina Pectoris
- ☐ Heart Attack
- ☐ Other Heart Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Kidney Disease
- ☐ Frequent Kidney or Bladder Infections
- ☐ Frequent Lung Infections
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Ulcers
- ☐ Colitis
- ☐ Other Stomach Disease
- ☐ Gallbladder Disease
- ☐ Jaundice
- ☐ Hepatitis/Liver Disease
- ☐ Gout
- ☐ Arthritis
- ☐ Migraine Headache
- ☐ Abnormal PAP Test
- ☐ Alcoholism
- ☐ Others _____

_____

women:

- ☐ Menstruating now
- ☐ Pregnant now

Please indicate any painful, numb, sensitive or injured areas on the figures:



Describe the sensation:

- ☐ stabbing
- ☐ dull ache
- ☐ burning
- ☐ radiating
- ☐ constant
- ☐ intermittent
- ☐ other

Rate the severity of the sensation from 1-10

(10 being most sensation) _____

Does your pain/sensation interfere with:

☐ Work? ☐ Sleep? ☐ Daily routine? ☐ Other? _____

_____

Operations: List and indicate approximate year. _____

_____

Hospitalizations (other than operations): List reasons and approximate dates. _____

_____

Serious injuries (other than the above): List and give approximate dates. _____

_____

Diagnostic X-rays: List and give approximate dates. _____

_____

Please list the location of all major scars, surgical & otherwise. _____

_____

Check if any blood relative has or has had any of the following:

- ☐ Stomach Ulcers
- ☐ Kidney Disease
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Migraine
- ☐ Asthma
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Allergies
- ☐ Arthritis
- ☐ Colitis
- ☐ Nervous Breakdown/Mental Illness
- ☐ Gout
- ☐ Alcoholism

Please list all medications, with dosage: _____

_____

Please list all vitamins and other supplements, with dosage: _____

_____

Do you have any allergies? No ☐ Yes ☐ If yes, to what? _____

_____

Do you exercise? No ☐ Yes ☐ What do you do and how often? _____

_____

What does your diet primarily consist of? _____

_____

Do you:

Drink soda? No ☐ Yes ☐ How much and how often? _____

Drink coffee? No ☐ Yes ☐ decaf ☐ How much and how often? _____

Drink tea? No ☐ Yes ☐ What kind, how much and how often? _____

Drink alcohol? No ☐ Yes ☐ What kind and how often? _____

Smoke? No ☐ Yes ☐ How many per day? _____ Quit smoking _____ ago.

Which of these do you like during your session? Check all that apply. quiet ☐ music ☐ conversation ☐

Have you ever had acupuncture before? yes ☐ no ☐ *if yes, where?* _____

Have you ever had Thai Bodywork before? yes ☐ no ☐ *if yes, where?* _____

Have you ever had Zero Balancing before? yes ☐ no ☐ *if yes, where?* _____

What level of pressure or strength do you like for bodywork? light ☐ medium ☐ strong ☐ extra strong ☐

Name:_____ Date: _____

Please check all that apply currently:

General *yes*

Sudden energy drop?..... ☐
Morning ☐ Afternoon ☐ Evening ☐
Often feel weak? ..... ☐
If localized, where?_____
Fatigue? ..... ☐
Always or frequently thirsty? ..... ☐
warm drinks ☐ cold drinks ☐
When ill, do you recover quickly? ..... ☐
or does it take a long time? ..... ☐
Recent weight gain or loss? ..... ☐
Have you taken a lot of antibiotics in the past? ☐
Were you vaccinated as a child? ☐as an adult? ☐
Do you usually feel colder than others?..... ☐
warmer than others? ..... ☐
strong dislike for cold weather? ..... ☐
warm weather? ..... ☐
Cold hands and feet? ..... ☐
Do you feel warm or feverish in the evening? ... ☐
Night sweats? ..... ☐
Chills? ..... ☐
Fevers? ..... ☐
Tremors? ..... ☐
Poor balance? ..... ☐
Perspire easily with little exertion? ..... ☐
Difficulty sleeping? ..... ☐
Never ☐ Sometimes ☐ Often ☐
Trouble falling asleep? ..... ☐
Frequent waking up? ..... ☐
Waking early in the morning, when? _____ ☐
Dream disturbed sleep? ..... ☐
Nightmares? ..... ☐
Other sleeping problems? _____
Frequent sighing? ..... ☐

Nervous System

Headaches? ..... ☐
Constant ☐ Often ☐ Sometimes ☐
Dizziness? ..... ☐
Fainting spells? ..... ☐
Seizures? ..... ☐
Numbness or tingling? ..... ☐
Wandering or transient pains? ..... ☐
Poor memory? ..... ☐
Concussion? ..... ☐
Other neurological problems? _____

Skin

Bruise easily? ..... ☐
Itchy? ..... ☐
Rashes? ..... ☐
Unusually dry skin, lips or mouth? ..... ☐
Dry scalp or dandruff? ..... ☐
Unusually oily skin? ..... ☐
Frequent or chronic pimples or acne?..... ☐
Sores or wounds that do not heal? ..... ☐
Eczema or psoriasis? ..... ☐
Loss of hair? ..... ☐
Other hair changes _____

Gastrointestinal *yes*

Bad breath? ..... ☐
Bad taste in mouth? ..... ☐
Difficulty swallowing? ..... ☐
Indigestion or heartburn? ..... ☐
Excess belching? ..... ☐
Excess gas? ..... ☐
Any special food that cause you difficulty? ..... ☐
Can you eat most foods without difficulty? ..... ☐
Poor appetite? ..... ☐
Recent change in appetite or eating habits? .... ☐
Do you need to maintain a limited diet? ..... ☐
Stomach pain? ..... ☐
worse after meals ☐ better after meals ☐
Feel bloated after meals? ..... ☐
Frequent nausea or vomiting? ..... ☐
Vomiting blood? ..... ☐
Abdominal pain or cramping? ..... ☐
Constipation? ..... ☐
Loose stools? ..... ☐
Chronic diarrhea? ..... ☐
Alternating constipation/loose stools? ..... ☐
Blood in stools/black stools? ..... ☐
Recent change in bowel habits? ..... ☐
Hemorrhoids? ..... ☐
Rectal pain or burning? ..... ☐
Use laxatives? ..... ☐

Eyes Ears Nose Throat

Glasses/contacts? ..... ☐
Poor vision? ..... ☐
Glaucoma? ..... ☐
Cataracts? ..... ☐
Poor night vision? ..... ☐
Pain in your eyes? ..... ☐
Spots in vision? ..... ☐
Colorblindness? ..... ☐
Dry, itching eyes? ..... ☐
Frequent tearing? ..... ☐
Ear pain? ..... ☐
Hearing loss? ..... ☐
Recent ☐ Chronic ☐
Ringing in ears? ..... ☐
High ☐ Low-pitched ☐
Chronic nasal congestion? ..... ☐
Chronic sinusitis? ..... ☐
Sneezing? ..... ☐
Inability to smell? ..... ☐
Frequent nosebleeds? ..... ☐
Constant dry throat? ..... ☐
Chronic or recurrent sore throat? ..... ☐
Always needing to clear your throat? ..... ☐
Sensation of lump in throat? ..... ☐
Recurrent sores on lips, tongue or cheeks? .... ☐
Bleeding gums? ..... ☐
Jaw tightness, pain or clicks? ..... ☐
Grinding teeth? ..... ☐
Lots of fillings or dental problems? ..... ☐

Respiratory *yes* *no*

Do you breathe as easily as you would like? ☐ ☐
Asthma? ☐
Emphysema? ☐
Bronchitis? ☐
Pneumonia? ☐
Constant cough? ☐
Coughing up blood? ☐
Excess phlegm? Color _____ ☐
Shortness of breath? ☐

Cardiovascular

High blood pressure? ☐
Low blood pressure? ☐
Irregular heartbeat? ☐
Palpitations? ☐
Chest pain or tightness? ☐
Worse with exercise or exertion? ☐
Worse when lying down? ☐
Trouble breathing at night? ☐
Difficult breathing, especially when lying down? ☐
Cough at night when lying down? ☐
Leg cramps with walking or exercise? ☐
Phlebitis? ☐
Feet/ankles or hands swelling? ☐
Blood clots? ☐

Musculoskeletal

Aware of any structural misalignments? ☐
Scoliosis ☐ Unequal bone growth ☐
Neck pain? ☐
Shoulder pain? ☐
Mid back pain? ☐
Low back pain? ☐
Joint pain? ☐
Which joints? _____ ☐
Does your joint pain seem to move around? ☐
Is your pain increase by cold? ☐
heat? ☐
damp weather? ☐
pressure? ☐
Is your pain improved by cold or ice? ☐
heat? ☐
touch or pressure? ☐
What else eases your pain? _____
_____

Urogenital

Urinate frequently? ☐
Urinate large amounts of clear urine? ☐
Is your urine dark and scanty? ☐
Pain or burning with urination? ☐
Ever passed blood in your urine? ☐
Get up at night to urinate? ☐
How many times? _____
Trouble urinating? ☐
Decrease in the force of your stream? ☐
Dribbling urine? ☐
Lose urine with cough, sneeze or laugh? ☐
Frequent bladder or kidney infections? ☐
History of herpes or other venereal infections? ☐
History of yeast infections? ☐

Mental-Emotional *yes*

Depression? ☐
Anxiety? ☐
Frequently irritable, or irrationally angry? ☐
Frequent mood swings? ☐
Nervous Breakdown? ☐
PTSD or Violent Crime Victim? ☐
Ever been treated for mental illness? ☐
Ever considered or attempted suicide? ☐
Other psychological concerns? _____
_____
_____

Men

Prostate problems? ☐
Trouble getting or maintaining an erection? ☐
Any unusual or irregular discharge? ☐
Pain in the scrotum or testicles? ☐
Chronic or recurrent itching? ☐
Vasectomy? ☐

Women

Number of pregnancies _____
Number of deliveries _____
Number of miscarriages _____
Number of abortions _____
Hysterectomy? ☐
Tubal ligation? ☐
Ever used birth control pills? ☐
Unusual vaginal discharge? ☐
Last PAP smear _____
Breast lumps? ☐
Breast sore or tender? ☐
Bloating before periods? ☐
Mood swings before periods? ☐
Irregular periods? ☐
Typical menstrual flow lasts _____ days?
Average number of days in cycle _____
Light flow? ☐
Moderate flow? ☐
Heavy flow? ☐
Clots? ☐
Cramping or pain with periods? ☐
before? ☐
during? ☐
after? ☐
Describe pain: dull ☐ sharp ☐ other _____
Low back pain with period? ☐
What do you do for the pain? _____
When was your last period? _____
Age of menarche (first period) _____
Menopause? age of onset _____ ☐
Hot flashes? ☐
Night sweats? ☐
Dry eyes, skin, vagina? ☐
Emotional changes? ☐

Is Is there anything not asked here that you would like to add?

_____
_____
_____

CONSENT FORM

I hereby authorize Kelly Kaeding MS LAc to treat me using Oriental medicine and relevant treatment modalities. I understand that Oriental medicine includes the use of acupuncture, acupressure, Thai and Oriental bodywork, moxibustion, cupping, and other methods to stimulate acupuncture points, meridians and overall body energy. Relevant treatment modalities may include craniosacral therapy and zero balancing. Kelly may also make dietary and herbal recommendations based on Oriental medical theory. I recognize that there are potential risks involved with acupuncture, such as discomfort, minor bruising, infection at the site of needle insertion, needle sickness, and temporary worsening of my symptoms. I also recognize that while acupuncture and Oriental medicine provide the potential benefits of painless and drug-free relief of my presenting condition and prevention of recurrences, there is no implicit guarantee of a cure from this therapeutic approach.

- ❑ **I understand all the information on this page and give consent for treatment.**

I acknowledge that I have been shown and have access to:

- ❑ The regulations regarding unprofessional conduct
- ❑ The method for filing a complaint
- ❑ The Notice of Privacy Practices for Protected Health Information

- ❑ I have read the Consent for Use or Disclosure of Health Information and agree to its terms. I am also acknowledging that I have access to this notice.

Please check above and sign below:

_____ _____
Signature of Client and/or Guardian date

_____
Client Name (printed)

Would you like to receive informative newsletters or similar literature from my practice? I send e-newsletters a maximum of four times a year which include recipes and hints for keeping healthy.

Please check **all** that apply:

- ❑ yes, email
- ❑ yes, US mail
- ❑ no, none of the above

Can we leave messages for you on your answering machine?
circle: **no** **yes** (home) **yes** (work) **yes** (cell)
Can we leave messages for you with people who answer your phone?
circle: **no** **yes** (home) **yes** (work)
(Note: messages usually concern appointment times or answers to your questions)