Acupuncture & Herbal Answers
Acupuncture, Zen Shiatsu, Chinese Herbal Medicine
1 Bartlett Court, Newport, RI 02840 AcuHerbalAnswers.com Dr. Lynn MacKesson 401-619-1912

Clinical Intake Form Date

Name	Birth date		Sex
Address	City, State, Zip		
Phone: Home	Work	Cell	
Email	Occupation		
Emergency Contact		Telephone	
Physician	Telephone	May We Contact Them?	
Referred by	Would you like to receive appt. reminder calls?		
Have you been treated with acupuncture or Chinese herbs before?			
Do you usually exhibit a fear of needles?			
PRIMARY REASON(S) FOR SEEKING TREATMENT			
When did this/these problem(s) begin?			
Did you receive a medical diagnosis?			
Was the problem related to: auto-accident	work	injury	chronic
What makes your symptom(s) better?			
Worse?			
Please rate your current pain or discomfort on a scale of 1 (can be felt) to 10 (unendurable):			
What other treatments have you tried?			

MEDICAL HISTORY (Include Dates, Check all appropriate boxes)

Date of last physical exam
Medications you have recently taken
Supplements you are currently taking
Allergies (food, drugs, chemicals, etc.)
Major illnesses or significant traumas
Surgeries

❍ Anemia
❍ Asthma
❍ Cancer
❍ Diabetes
__ Endocrine Disorder
❍ Hepatitis
❍ Heart Disease
❍ High Blood Pressure
❍ HIV/AIDS
❍ Lyme Disease
❍ Pneumonia
❍ Seizures
❍ Stroke
❍ Tuberculosis
❍ High Cholesterol

FAMILY MEDICAL HISTORY (Check All That Apply):

__ Alcoholism / Addiction
__ Arthritis
__ Cancer
__ Diabetes
__ Heart Disease
__ High Blood Pressure
__ Low Blood Pressure
__ Psychological Disorders
__ Stroke

PERSONAL

Height Weight Weight Maximum When?
Exercise (please describe):
Stress: occupational physical chemical emotional familial social financial
(please circle) Where do you feel it?
What helps dissipate it?
Do you smoke? Did you used to smoke? How much? For how long?
Do you drink alcohol? How many drinks per week?
Do you drink caffeinated beverages? What kind? How many per day?
Please list any other drug use:

Please describe your usual **diet**:

Morning

Afternoon

Evening

Please describe your **sleep** cycle: Hours Difficulty **falling** or **falling back** to sleep
Light sleep Frequent waking Early waking Vivid or disturbing dreams

Do you tend to feel **hotter** or **colder** than those around you?

PERSONAL SIGNS AND SYMPTOMS (Please check any that apply to you)

General

__ Cravings *for what?*
__ Localized Weakness *where?*
__ Sudden Energy Drop *when?*
__ Bleed or Bruise Easily
__ Chills
__ Cold Abdomen
__ Cold Hands / Feet
__ Fatigue
__ Fever
__ Night Sweats
__ Poor Appetite
__ Poor Balance
__ Strong Thirst for Hot/Cold
__ Sweat Easily
__ Tremors
__ Weight Gain
__ Weight Loss

Your general Mood: Angry Joyful Worried/Pensive Sad Frightened

Musculoskeletal

What part? *For How Long?* *Is Range of Motion Limited?*
Is it effected by weather changes, Pressure drop, damp, cold, heat, touch? (circle)

__ Back Pain
__ Facial Pain
__ Foot / Ankle Pain
__ Hand / Wrist Pain
__ Hernia
__ Hip Pain
__ Joint Pain / Stiffness
__ Knee Pain
__ Muscle Atrophy
__ Muscle Pain
__ Muscle Twitches
__ Muscle Weakness
__ Neck Pain / Tightness
__ Numbness
where?
when?
__ Osteoarthritis
__ Osteoporosis
__ Paralysis
__ Rheumatoid Arthritis
__ Sciatica
__ Shoulder Pain
__ Spinal Curvature
__ Swollen Hands / Feet
__ Tingling
__ Trauma/Broken Bones
Where & when?
__ Tremors
__ Vertebral/Disc Disorder

Head & Throat

__ Blurry Vision
__ Cataracts
__ Concussions
__ Dental Problems
__ Difficulty Swallowing
__ Dizziness
__ Dry Eyes
__ Earaches
__ Eye Pain / Strain
__ Facial Pain
__ Frequent Sore Throats
__ Headaches/ Migraines
Frequency Location
Auras, other changes
__ Head Injury
__ Hearing Loss
__ Hyper/Hypo-Thyroid
__ Jaw Clicks / TMJ
__ Limited Sense of Smell/Taste
__ Mouth / Lip Sores
__ Night Blindness
__ Nose Bleeds
__ Ringing in Ears
__ Sinus Problems
__ Spots in Vision
__ Tearing
__ Teeth Grinding/Jaw clenching *Day/Night*
__ Unusual Smells/Tastes
__ Vision Loss
How long have you worn glasses/contacts?

Skin & Hair

__ Acne
__ Change in Skin Texture
__ Dandruff
__ Dry Skin/Hair
__ Eczema
__ Fungal Infection
__ Hair Loss
__ Hives
__ Itching
__ Nails ridged or weakened
__ Psoriasis
__ Purpura
__ Rashes
__ Recent Moles
__ Recent skin discoloration
__ Ulcerations
__ Warts

Respiratory

__ Allergies Please list:

__ Asthma
__ Bronchitis
__ Chest Pain
__ Coughing Blood
__ Coughing Up Phlegm
Color:
__ Difficulty Breathing
When?
__ Difficulty with deep breaths
__ Emphysema
__ Frequent Common Colds
__ Persistent Cough
__ Pleurisy
__ Pneumonia
__ Post Nasal Drip
__ Sinus Problems
__ Wheezing

Cardiovascular

__ Anemia
__ Blood Clots
__ Chest Pain
__ Fainting
__ Heart Murmurs
__ High Blood Pressure
__ Irregular Heartbeat
__ Low Blood Pressure
__ Palpitations
__ Phlebitis
__ Rapid Heartbeat
__Varicose/Spider Veins

Gastrointestinal

Please describe your **bowel movements**: *frequency: # per day/week*
Light brown blackish dark bloody mucous smelly soft hard large long pellet-like diarrhea constipation alternating diarrhea & constipation small difficult to pass frequent urgent incomplete satisfying undigested food in stools

__ Abdominal Pain / Cramps
__ Acid Reflux/GERD
__ Bad Breath
__ Belching
__ Celiac
__ Changes in Appetite
__ Chronic laxative use
Type, frequency:
__ Crohn's Disease
__ Constipation
__ Diarrhea
__ Discomfort after eating
__ Gallbladder Problems
__ Gas / Bloating
__ Heartburn
__ Hemorrhoids
__ High Cholesterol
__ IBS
__ Indigestion
__ Nausea
__ Parasites
__ Rectal Pain
__ Ulcers
__ Vomiting

Neuro-Psychological

__ ADD / ADHD
__ Anxiety
__ Bad Temper / Irritability
__ Bipolar
__ Concussion *When?*
__ Depression
__ Dizziness/Vertigo
__ Easily Stressed
__ Loss of Consciousness
__ Lack of Coordination
__ Loss of Balance
__ Memory Loss
Short Term *Long Term*
__ Mood Swings
__ Obsessive Thoughts
__ Over thinking
__ Panic Attacks
__ Seizures
__ Shakes/Tremors
__ Shingles
__ Speech Problems
__ Stress
__ Tics *Where?*

Are you currently undergoing pharmaceutical or psychotherapy?

Genito-Urinary

__ Blood in Urine
__ Burning Urination
__ Dribbling
__ Frequent Urination
__ Genital Itching
__ Genital Pain
__ Inability to Hold Urine
__ Kidney Stones
__ Libido Excessive/Low
__ Painful Urination
__ Night Urination: *How often?*
__ Pause of Urine Flow
__ Urinary Tract Infection
__ Urinary Urgency

FEMALE

__ Breast Lumps
__ Breast Tenderness
__ Difficult/Painful Intercourse
__ Endometriosis
__ Frequent Miscarriage
__ Frequent Vaginal Infections
__ Infertility
__ Nipple Discharge
__ Ovarian Cysts
__ Pelvic Infection
__ Polycystic Ovarian Syndrome
__ Sexually Transmitted Disease
__ Spotting
__ Uterine Fibroids
__ Vaginal Discharge
__ Vaginal Dryness

Any possibility you are pregnant? **Birth Control:** Type for how long?

Menses: Age at first menses Date of last menses Duration of period

Number of Pregnancies Number of Births Difficulties:

Describe your average cycle: Length of cycle: Color of blood:

Pain Clots Cramping Regular/Irregular Light/Heavy

PMS: Breast Tenderness Pain Irritable Emotional Digestive Problems

Menopause: When? Associated symptoms:

Are you comfortable where you are now?

MALE

__ Erectile Dysfunction
__ Fertility Problems
__ Frequent Nocturnal Emissions
__ Frequent Seminal Emissions
__ Interrupted Urine stream
__ Painful / Swollen Testicles
__ Penile Discharge
__ Premature Ejaculation
__ Prostate Problems
__ Sexually Transmitted Disease

Please circle your Favorite, and cross-out your Least Favorite for the following:

Season:	Spring	Summer	Late/Indian Summer	Autumn	Winter
Climate:	Windy	Hot	Humid/Damp	Dry	Cold
Flavor:	Sour	Bitter	Sweet	Acrid/Pungent/Spicy	Salty
Color:	Green	Red	Yellow, Orange	White, Silver, Gray	Blue, Black Purple
Time of Day:	Predawn	Morning	Afternoon	Evening	Night

Acupuncture & Herbal Answers

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Upon request, we will provide you with a printed receipt.
1) If you wish to change an appointment, please give at least 24 hours advance notice. Acupuncture & Herbal Answers will charge the full treatment price for any missed appointments or late cancellations.
2) All herb sales are final. Acupuncture & Herbal Answers is not able to offer refunds on any herbs or herbal products.
3) Herbal prescriptions are intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.
I understand the above information and guarantee this form was completed to the best of my knowledge:
Signature: *Date:*

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Signature: *Date:*

Initial Consultation:

C/C
2
3
Pulse
Tongue
Type
TCM Dx
Tx Protocols/Plan: **Tx**