YIN FIRE
Acupuncture
1761 Ogden St. Denver, Co 80218

Initial Visit Intake

Patient Name: Date:

Date of Birth: Time of Birth: Gender: Height: Weight:

Occupation:

Home address:

Emergency contact name and number:

What is the primary reason for coming in for treatment?

How long has this been occurring?

Have you been given a diagnosis by a physician? If so, please describe.

What other therapies have you tried?

Medical History:
Please check all current/past conditions or diagnoses that apply.

☐ Allergies ☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ Seizures
☐ Stroke ☐ Thyroid Diseas ☐ Heart Disease ☐ Lung Disease

Other (please describe below) Other conditions or previous diagnoses

Any previous accidents of significant traumas? If so please describe

Surgeries or other significant medical interventions? If so please describe.

Please list all prescription medications (current or within last 2 months).

Please list any vitamins, supplements or herbs you are currently taking.

Do you exercise? ◯ Yes ◯ No

☐ Rarely Sometimes (2 days/week or less) ☐ Often (3 days/week or more)

What type of exercise?

Do you have any issues associated with sleep? If so please describe. (falling asleep, staying asleep, etc.)

Any dietary restrictions? (gluten free, other food allergies, vegetarian, vegan, etc.)

What are your symptoms when you eat these foods?

General Health:

☐ Insomnia ☐ Disturbed Slee ☐ Night Sweats ☐ Sweating Easil ☐ Generalized Weakness
☐ Weight Gain ☐ Weight Loss ☐ Edema ☐ Cold Hands ☐ Noticeable Fatigue
☐ Cold Feet ☐ Generally Colc ☐ Generally Hot ☐ Strong Thirst ☐ Numbness or Tingling
☐ Excessive Hunger ☐ Tremors/Trembling ☐ Excessive Hunger ☐ Dizziness/Vertigo
☐ Lack of Appetite

Other unusual symptoms or changes in your general health?

Musculoskeletal:

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Hip Pain
- ☐ Arthritis
- ☐ Hand/Wrist Pain
- ☐ Foot/Ankle Pain
- ☐ Muscle Weakness
- ☐ Overall Pain

Other Musculoskeletal symptoms? Please describe.

Psychological and Mental:

- ☐ Depression
- ☐ Anxiety
- ☐ Stress
- ☐ Irritability/Frustration
- ☐ Poor Memory
- ☐ Lack of Concentratio
- ☐ Lack of Motivation
- ☐ Addiction

Other emotional symptoms? Please describe.

Skin and Hair:

- ☐ Rash
- ☐ Ulcerations
- ☐ Acne
- ☐ Eczema or Psoriasis
- ☐ Hives
- ☐ Itching
- ☐ Hair Loss
- ☐ Dry Skin/Scalp

Other skin/hair symptoms? Please describe.

Face and Head:

- ☐ Migraines/ Headache
- ☐ Eye Pain/Strain
- ☐ Eye Floaters/Spots
- ☐ Poor Vision
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Recurrent Sore Throa
- ☐ Sinus Congestion
- ☐ Nose Bleeds
- ☐ Sinus/Facial Pain
- ☐ Jaw Clicks/Pain
- ☐ Lip/Mouth Sores
- ☐ Dry Mouth

Other face/head problems? Please describe.

Respiratory:

☐ Difficulty Breathing ☐ Frequent Colds ☐ Cough Asthma ☐ TB Diagnosis

☐ Sinus Infections ☐ Excessive Phlegm

Other respiratory problems? Please describe.

Heart/Cardiovascular:

☐ Palpitations ☐ Chest Pain ☐ High Blood Pressure ☐ Previous Heart Attac

☐ Previous Stroke ☐ Bleeding Disorder ☐ Clotting Disorder ☐ Congestive Heart Failure

☐ Other Cardiovascular Disease

Other Heart or Cardiovascular Problems? Please describe.

Digestion/Elimination:

☐ Abdominal Distention/Bloating ☐ Abdominal Cramping/Pain

☐ Gas Nausea/Vomiting ☐ Indigestion Diarrhea

☐ Incontinence/Urgency ☐ Constipation

☐ Hemorrhoids ☐ Difficulty with bowel movemer

☐ Parasites ☐ Blood in stool

Other problems with digestion and elimination? Please describe.

Urination:

☐ Pain on Urination ☐ Frequent Urination ☐ Urgency to Urinate

☐ Incontinence/Leakage ☐ Decreased Urination ☐ Waking Often to Urinat

☐ Kidney Stones ☐ Discharge or Cloudy Urine ☐ Blood in Urine

Other urinary symptoms? Please describe.

Men's Health:

☐ Genital Sores/Rash ☐ Erectile Dysfunction ☐ Decreased Libido
☐ Excess Libido

Other men's health symptoms? Please describe.

Women's Health:

☐ Painful Periods ☐ Heavy Flow ☐ Light Flow
☐ Clots ☐ PMS ☐ Discharge
☐ Irregular Periods ☐ Absent Periods ☐ Menstrual Cramps
☐ Past Miscarriage ☐ Fertility Issues ☐ Endometriosis

Other women's health symptoms? Please describe.

Have you been pregnant or given birth in the past 3 years? ☐ Yes ☐ No ☐ Maybe/Not Sure

Age of first period ☐ Age at menopause (if applicable) ☐

By signing below, I certify that the information I have provided is correct and accurate to the best of my knowledge. Patient or Legal Guardian Name:

Signature:

Date (mm/dd/yyyy):