Jyoti Elias, L·Ac·, MS

Patient Intake Form

Name (Last, First): _____

Date of Birth: _____ Age: _____ Gender: _____

Place of Birth: _____ Height: _____ Weight: _____

Address (Street): _____

City: _____ State & Zip Code: _____

Mobile Phone: _____ Email: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status:

Single _____ Living with Partner _____ Married _____ Divorced _____ Widowed _____

Referred By: _____

In Case of Emergency Notify: _____ Phone: _____

Have you been treated by acupuncture or Chinese Medicine before? Yes _____ No _____

Date of Last Physical Examination: _____ Name of Physician: _____

Clinic's Policy:

Fees for consultation, acupuncture treatment and remedies are paid to the clinic at the time of appointment. If I need to cancel or reschedule my appointment, I will call at least 24 hours before my scheduled appointment. For cancellations made less than 24 hours in advance, I will be charged the full appointment fee.

I have read the above and abide by the rules and conditions.

Signature: _____ Date: _____

Family History: Complete for each family member. Place an X in the box, indicating any of the illnesses that they have ever had:

		Mother	Father	Sibling	Sibling	Spouse	Child
Allergies							
Blood Disorder/Anemia							
Cancer or Tumours							
Diabetes							
Heart Disease							
High Blood Pressure							
Kidney/Bladder Disorders							
Intestinal Disorders							
Seizures							
Stroke							
Substance Abuse							
Tuberculosis							
Other							

Past Medical History: Check the box for any disorder you have experienced.

- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Drug Allergies
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Headache
- ☐ Cancer or Tumour
- ☐ Reproductive System Disorder
- ☐ Tuberculosis
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Seizures
- ☐ Thyroid Disorder
- ☐ Kidney Disorder
- ☐ Stomach Disorder
- ☐ Intestinal Disorders
- ☐ Urinary Tract Disorder
- ☐ Asthma or Bronchitis
- ☐ Musculo-Skeletal Disorder
- ☐ Organ Transplant
- ☐ Depression
- ☐ Psychological Disorder
- ☐ Other _____

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation: Enter most recent first. (Do not include any uncomplicated pregnancies.)

	Year	Operation or Illness
1st Hospitalization	_____	_____
2nd Hospitalization	_____	_____
3rd Hospitalization	_____	_____

Have you had more than three hospitalizations? ☐ Yes ☐ No

Medicines: Please list all medicines that you are taking currently, including vitamins, supplements and herbs:

_____ _____

_____ _____

_____ _____

Habits: Please check any of the habits listed below which apply to you now or in the past:

☐ Use of Tobacco: # of packs/day ____ Age started smoking: ____

☐ Use of Alcohol: # of drinks/day ____ Age started drinking: _____

☐ Use of Caffeine: # coffee/day ____ # tea/day ____ # colas/day ____

☐ Use of Drugs: Please specify type and frequency: _____

Previous Pregnancies:

Total Pregnancies: _____ Living: _____ Ectopics: _____ Miscarriages: _____ Terminations: ____

Please place a check next to any current conditions you are experiencing or have experienced in the past: YEAR

Head and Neck
- ☐Dizziness
- ☐Fainting
- ☐Neck Stiffness
- ☐Enlarged Lymph Glands
- ☐Headaches
- ☐Other

Skin
- ☐Hives
- ☐Rashes
- ☐Changes in Moles/Lumps
- ☐Eczema
- ☐Night sweating
- ☐Excess Sweating
- ☐Dryness
- ☐Bruise Easily
- ☐Other

Ears
- ☐Infection
- ☐Ringing
- ☐Decreased Hearing
- ☐Other

Eyes
- ☐Blurred Vision
- ☐Visual Changes
- ☐Poor Night Vision
- ☐Spots
- ☐Eye Inflammation
- ☐Other

Female
- ☐Urinary Tract Infections
- ☐Vaginal Infections
- ☐Pain/Itching of Genitalia
- ☐Genital Lesions
- ☐Discharge
- ☐Pelvic Inflammatory Disease
- ☐Abnormal Pap Smear
- ☐Irregular Periods
- ☐Painful Periods
- ☐Premenstrual Syndrome
- ☐Abnormal Bleeding
- ☐Menopause
- ☐Breast Lumps
- ☐Venereal Disease
- ☐Other

Male
- ☐Pain/Itching of Genitalia
- ☐Genital Lesions
- ☐Genital Discharge
- ☐Impotence
- ☐Weak Urinary Stream
- ☐Lumps in Testicles
- ☐Venereal Disease
- ☐Other

Cardio-Vascular
- ☐Palpitations
- ☐Chest Pain or Tightness
- ☐Rapid Heartbeat
- ☐Irregular Heartbeat
- ☐Poor Circulation
- ☐Swelling of Ankles
- ☐Phlebitis

Gastrointestinal
- ☐Nausea
- ☐Indigestion
- ☐Stomach Pain
- ☐Diarrhea
- ☐Constipation
- ☐Poor Appetite
- ☐Excessive Hunger
- ☐Vomiting Blood
- ☐Blood in Stools
- ☐Black Stools
- ☐Hemorrhoids
- ☐Gall Bladder Disorder
- ☐Recent Changes in Weight
- ☐Food Cravings
- ☐Other

Muscle and Joint
- ☐Joint Disorder
- ☐Sore Muscles
- ☐Weak Muscles
- ☐Difficulty Walking
- ☐Spinal Curvature
- ☐Back Pain
- ☐Other

Neurological
- ☐Seizures
- ☐Tremors
- ☐Numbness or Tingling of Limbs
- ☐Pain
- ☐Paralysis
- ☐Other

Nose, Throat, Mouth
- ☐Bleeding
- ☐Sinus Infection
- ☐Hay Fever/Other Allergies
- ☐Sore Throat
- ☐Hoarseness
- ☐Difficulty Swallowing
- ☐Changes in Taste
- ☐Changes in Smell
- ☐Oral Ulcers
- ☐Other

Respiratory
- ☐Chronic Cough
- ☐Coughing Up Blood
- ☐Coughing Up Phlegm
- ☐Difficulty Breathing
- ☐Wheezing/Asthma
- ☐Frequent Colds
- ☐Other

General
- ☐Insomnia
- ☐Vivid Dreams/Nightmares
- ☐Depression
- ☐Agitation
- ☐Fatigue
- ☐Aversion to Cold
- ☐Frequent Urination
- ☐Irritability
- ☐Thirst
- ☐Other