San Jose Integrative Medicine

ACUPUNCTURE & MASSAGE HEALTH INTAKE FORM

PATIENT INFORMATION

Name:		Date:
Date of Birth:	Age:	Gender:
Address:		
City, State, Zip:		

Phone:

May we leave detailed messages regarding your appointments at this number? ☐ Yes ☐ No

Would you like to receive a text reminder for appointments? ☐ Yes ☐ No

Email:

May we email you information, appointment reminders, and periodic announcements from our office? ☐ Yes ☐ No

If you answered no to any of the above, please specify if we can :

* "information" can mean lab work, billing statements, or anything pertinent to your current medical condition

☐ Leave a name and number only at the phone number provided ☐ Mail information to your home address ☐ Only mail billing statements to my home

Emergency Contact (name and phone):
Relationship to you:

Insurance Company_____ ID #_____

When were you last seen by a medical professional and for what condition?

How did you find our office?
Search words used?

WHAT ARE YOUR CURRENT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE.

1.

2.

3.

4.

5.

6.

MEDICAL AND FAMILY HISTORY

Please list your current and past diagnoses (if any):

Please list past hospitalizations and surgical procedures (include date and hospital):

Have you been fully vaccinated? ☐ Yes ☐ No ☐ Unsure

List any known allergies to medications, foods or other substances as well as your reaction:

MEDICATIONS AND SUPPLEMENTS

List all current medications, vitamins, herbs and other supplements you take, including dosages.

Medications:	Vitamins, Herbs, Other Supplements:

FAMILY HISTORY

List any serious health conditions your family members have experienced. Include diabetes, heart disease, autoimmune disease, cancer, additions, eating disorders, mental disorders, allergies, genetic disorder or any other major concerns.

Condition:	Family Member:	Age of onset/age of death:

General Health Information

Please check all that apply:

	Yes
Do you follow a special diet?	☐
Do you eat processed food more than once a week?	☐
Do you drink more than five alcoholic drinks a week?	☐
Are you content with your current weight?	☐
Does your weight fluctuate?	☐
Constipation	☐
Diarrhea	☐
Recent changes in bowel habits	☐
Recent changes in appetite	☐
Any excessive gas or bloating	☐
Have you been diagnosed with IBS	☐
Blood or mucous in stool	☐
Abdominal pain or upset stomach	☐
Heartburn/reflux	☐
Nausea or vomiting	☐
Sinus problems	☐
Chronic congestion or nasal discharge	☐
Excessive tearing or dry eyes	☐
Tooth pain	☐
Ringing or buzzing in ears	☐
Ear infections	☐
Difficulty swallowing	☐
Loss of vision	☐
Loss of hearing	☐
Chronic cough	☐
Bronchitis	☐
Tuberculosis or pneumonia	☐
Difficulty breathing	☐
Asthma or Emphysema	☐
Chest pain	☐
High or low blood pressure	☐
Heart palpitations	☐
Cold extremities	☐

	Yes
Tension	☐
Anxiety	☐
Depression	☐
Irritability	☐
Inability to concentrate	☐
Eating disorder	☐
Fatigue	☐
Excessive hunger or thirst	☐
Hypoglycemia	☐
Autoimmune disorder	☐
Heat or cold intolerance	☐
Fever or excessive sweating	☐
Diabetes	☐
Thyroid conditions	☐
Hair loss	☐
Dry skin	☐
Cold hands & feet	☐
Exercise	☐

FEMALE HEALTH INFORMATION (skip if male)

Please check all that apply:

	Yes		Yes
Pelvic Inflammatory Disease	☐	Fibroids	☐
Chronic yeast or vaginal discharge	☐	Urinary tract infections	☐
Loss of bladder control	☐	Breast cancer or benign tumors	☐
Blood in urine	☐	Painful urination	☐
Chronic vaginal itching or burning	☐	Low libido	☐
Insomnia	☐	PMS/PMDD	☐
Hot flashes/night sweats	☐	Decreased physical agility	☐
Vaginal dryness	☐	Memory changes	☐

MENSTRUAL HISTORY

Date of last period:

Painful periods	☐
Irregular periods	☐

OBSTETRIC HISTORY

Are you currently pregnant?	☐
Are you trying to conceive?	☐
Have you had problems with infertility?	☐
Any pregnancy complications?	☐
Are you currently breast feeding?	☐

MALE HEALTH INFORMATION (skip if female)

Please select all that apply:

	Yes		Yes
Decreased or absence of libido	☐	Insomnia	☐
Erectile dysfunction	☐	Hot flashes or night sweats	☐
Muscle weakness	☐	Decreased physical agility	☐
Mood changes	☐	Memory changes	☐

MUSCULOSKELETAL HEALTH INFORMATION

Do you have pain, numbness, tingling, or limited mobility in any of the following areas?
Please check all that apply:

FRONT	Yes
Head	☐
Jaw	☐
Neck	☐
Chest	☐
Abdomen	☐
Legs	☐

BACK	
Head	☐
Neck	☐
Upper back	☐
Mid back	☐
Low back	☐
Legs	☐

LEFT	Yes
Shoulder	☐
Upper arm	☐
Elbow	☐
Lower arm	☐
Hand	☐
Upper leg	☐
Knee	☐
Lower leg	☐
Foot	☐

RIGHT	
Shoulder	☐
Upper arm	☐
Elbow	☐
Lower arm	☐
Hand	☐
Upper leg	☐
Knee	☐
Lower leg	☐
Foot	☐