Initial Intake Form

Fox Herbs & Acupuncture LLC
http://www.foxhealing.com
828-318-5369

Please fill out this confidential questionnaire so we can create the best treatment plan for you.

Name: Age: Birth Date:

Address:

City: State: Zip:

Phone number:

E-mail address: Occupation:

If under 18, person responsible for your account:

Emergency Contact- Name: Contact Phone:

Who shall I thank for referring you?

Have you received acupuncture before? □ Yes □ No Have you taken herbs before? □ Yes □ No

In order of priority, please list up to three health concerns for which you are seeking treatment and how long you have been experiencing them:

1. ______________________________
2. ______________________________
3. ______________________________

What other forms of treatment have you sought?

____

What helps your condition?______________________________

What aggravates it?______________________________

What would you like to achieve with our sessions?

____

Please list any surgeries or major health incidents (accidents, etc.) in your life and the date of occurrence:

____

____

____

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Please indicate if any of the following pertain to you:

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Rx □ Pregnancy

Please indicate how frequently you consume the following: Coffee: Soda:

Water: Alcohol: Dairy: Meat: Sugar:

Tobacco: Marijuana: Recreational/Ceremonial Drugs:

Please list any prescription or over-the-counter medications and supplements you are presently taking:

Medication / Supplement Reason For how long now?

____

____

____

How many hours of sleep do you get each night? _____ Do you experience: □ Difficulty falling asleep

□ Difficulty staying asleep □ Interrupted sleep □ Nightmares □ Vivid dreams □ Wake up groggy

How many bowel movements do you have in a day? _______________________________

Are your bowel movements: □ Well-formed □ Loose □ Small pebbles □ Tan □ Almost black

□ Easy to pass □ Difficult to pass □ Contains undigested food □ Sticky, like you have to wipe a lot

How would you rate your energy level on a scale of 1-10, with 10 being the highest: _______

How would you rate your stress level on a scale of 1-10, with 10 being the highest: ________

Please list your primary sources of stress: ____

____

What emotions do you feel on a daily or weekly basis? How much do they impact your life?

____

What do you do in order to manage your stress/emotions and take care of yourself?

____

How many hours do you work per week? ______ Do you like your work? _____________________

How often do you exercise or move your body? ___________________________

What are your passions in life? What makes you feel most alive?

____

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Please indicate the symptoms you currently experience or have experienced in the past:

Condition	Current	Past	Condition	Current	Past
Excessive appetite	□	□	Eye Problems	□	□
Diarrhea	□	□	Jaundice	□	□
Digestive problems	□	□	Difficulty ingesting	□	□
Gas or bloating	□	□	Belching	□	□
Obsession	□	□	Acid Reflux / heart burn	□	□
Worry thoughts	□	□	Easily Frustrated/ angered	□	□
Lack of appetite	□	□	Depression	□	□
Fatigue	□	□	Difficulty making decisions	□	□
Low energy after a meal	□	□	Gallstones	□	□
Sweet cravings	□	□	Ringing in the ears	□	□
Hemorrhoids	□	□	Brittle hair or nails	□	□
Low blood pressure	□	□	High cholesterol	□	□
Headaches	□	□	Dizziness	□	□
Insomnia	□	□	Cough	□	□
Heart palpitations	□	□	Shortness of breath	□	□
Nightmares	□	□	Decreased sense of smell	□	□
Mentally restless	□	□	Colitis/diverticulitis	□	□
Chest pain	□	□	Tightness in the chest	□	□
Poor memory	□	□	Constipation	□	□
Sadness/loneliness	□	□	Grief/ Nostalgia	□	□
Agitation/Fidgeting	□	□	Claustrophobia	□	□
Lower back pain	□	□	Arthritis	□	□
Knee pain/ problems	□	□	Sluggishness/Grogginess	□	□
Hearing impairment	□	□	Nausea	□	□
High or low libido	□	□	Heavy feeling	□	□
Hair loss	□	□	Dark circles under eyes	□	□
Urinary problems	□	□	Blood clotting disorder	□	□

I usually feel (check all that apply): □ Hot □ Cold □ Thirsty □ Damp □ Dry

FOR WOMEN:

Age of first period: ______ Date of last period: _________ Number of days between periods: _____

Number of days of flow: ____ Number of pregnancies: _____ Miscarriages: _____ Abortions: _____

Are you currently sexually active? □ Yes □ No Partners are: □ Men □ Women

Please indicate color of blood and number of pads/tampons per day of flow below:

	Color of Menstrual Blood:			Cramping:			Number of Pads:		
	*Pale/light-red	* Bright-red	* Dark-red/brown	* Mild	*Moderate	*Severe	*1-3	*4-7	*8+
Day 1,2	□	□	□	□	□	□	□	□	□
Day 3,4	□	□	□	□	□	□	□	□	□
Day 5+	□	□	□	□	□	□	□	□	□

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Please indicate if you experience the any of these symptoms during your menses:

- ◻ Lower back pain
- ◻ Diarrhea
- ◻ Constipation
- ◻ Moodiness/Weepy
- ◻ Breast pain/soreness
- ◻ Blood clots
- ◻ Increased appetite
- ◻ Decreased appetite
- ◻ Headache
- ◻ Nausea
- ◻ Insomnia
- ◻ More tired
- ◻ Hemorrhoids
- ◻ Bloating
- ◻ Down-bearing sensation
- ◻ Scant or late menses
- ◻ Irregular menses

Please indicate if you experience any of these other gynecological symptoms:

◻ Vaginal dryness ◻ Vaginal discharge ◻ Yeast infections ◻ Urinary tract infections

Please indicate if you have been diagnosed with any of the following:

◻ Fibroids ◻ Fibrocystic breasts ◻ Endometriosis ◻ Ovarian Cysts ◻ Polycystic Ovary Syndrome

◻ Pelvic Inflammatory Disorder ◻ STDs (please list:) ______________________________

FOR MEN:

Date of your last prostate exam: Are you currently sexually active? ◻ Yes ◻ No

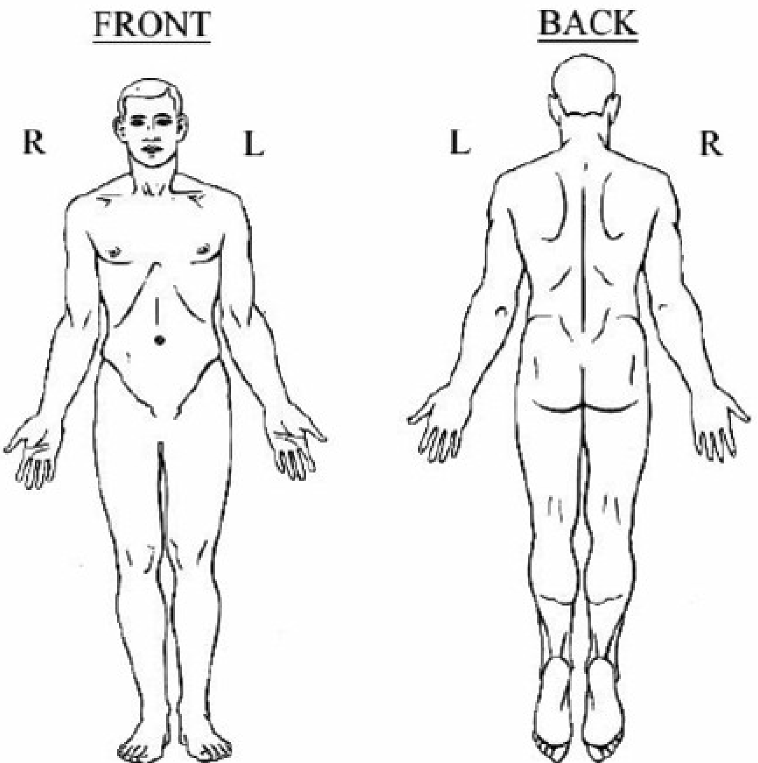
Partners are: ◻ Male ◻ Female Please list any STDs you have: ______________________________

Please explain any concerns you may have with your sexual function or libido:

____

PAIN:

If you experience any physical pain, please indicate where (with X's or circles on the chart →).



When did it start?___________________________

On a scale from 1-10 (10 is the worst), how bad is your pain? _____________

How would you characterize your physical pain?

- ◻ dull/achy
- ◻ sharp/stabbing
- ◻ burning
- ◻ tingling /numbness
- ◻ electrical
- ◻ continuous
- ◻ comes and goes
- ◻ fixed location
- ◻ moves around
- ◻ shooting/ radiating

Is there anything else you'd like us to know?

____

Thank you for taking the time to complete this form! We look forward to working with you.

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