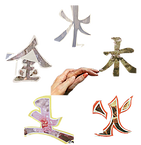
[[](https://www.janbullacupuncture.com/)](https://www.janbullacupuncture.com" \t "_self)[**Nura Acupuncture**](https://www.janbullacupuncture.com)**,** [Jan Bull, MA, L.Ac](https://www.janbullacupuncture.com)

***A Loving Light for hope and healing***

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**New Patient Intake Form**

All answers are confidential.

Name : Identified Gender :

Date of Birth :

Address:

Cell: Texts ok? Y/N? Email:

Occupation :

Relationship (Single, Married, Widowed, Divorced, Separated):

Emergency contact Person, Phone, Email and Relation to you:

Insurance company (if applicable):

Additional information you want to add:

Your e-signature Date

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## Medical Concerns and History

**Chief Complaint(s) : What are your most important goals and/or health concerns and their onset time for this visit?** What has previously helped with these conditions? Do they impair your daily activities?

**Medications/Vitamins/food supplements Dosage For what condition?**

**Surgical operations : Year Operation/illness Hospital/location**

**Significant Laboratory Test and Imaging (e.g. Pap/Gyn Mammo, Physical, Stool, Prostate, HIV/STD, osteoporosis, Cholesterol, blood, EKG, MRI etc)**

**Month/Year Diagnosis Hospital/clinic Blood Test and result**

**How was your childhood health? Any birth traumas?**

**Any hospitalizations (condition, date)**

**Check any conditions you have had (“me’ or blood relative e.g dad, mom, sister, brother)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Coronovirus** | **Allergies** | **Diabetes** | **Migraines** | **High Blood pressure** |
| **Heart disease** | **CVA (Stroke)** | **Cancer** | **Emphysema** | **Bleeding** |
| **Asthma** | **Pneumonia** | **Tuberculosis** | **Glaucoma** | **Menigitis** |
| **Chicken pox** | **Mumps** | **Measles** | **Syphilis** | **Gonorrhea** |
| **Multiple sclerosis** | **Polio** | **Epilepsy** | **Jaundice** | **Heptatitis** |
| **Paralysis** | **Migraines** | **Vein condition** | **Rheumatic fever** | **Thyroid** |
| **Mononucleosis** | **HIV** | **Candidiasis** | **Cystitis** | **Lung illnesses** |
| **Liver illnesses** | **Kidney illnesses** | **Stomach illness** | **Obesity** | **Mental Illiness** |

**Other:**

**Family History: Alive? Deceased/Age Current health issues/or cause of death**

**Mother**

**Father**

**Children**

**Brother(s)**

**Sister(s)**

**What is your birth order**

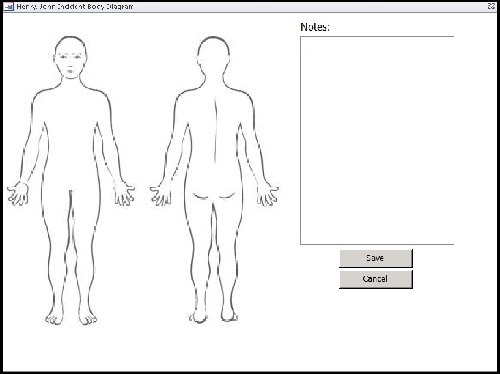
## Patient Patterns and Pain Profile

Please indicate any areas of Pain, Scars, lumps or numbness .

Indicate type of pain: sharp, cramping, fixed, burning, dull, aching, moving

What lessens the pain: Pressure, exercise, cold, heat

What worsens the pain: Pressure, exercise, cold, heat



## Chinese Patterns

. Check all which apply:

|  |  |
| --- | --- |
| Overall temperature (kidney function)   * Cold hands * Cold feet * Sweaty hands * Sweaty feet * Feel like you “run” hot body (your perception) * Feel like you “run” cold * Afternoon hot flashes * Night sweats * Heat in the hands, feet and chest (5 palm heat) * Hot flashes any time of day * Thirsty * Perspire easily * Lack of perspiration * Difficulty keeping eyes open in daytime * Fear prominent emotion | Energy level (LU/KD function)   * Shortness of breath * General weakness * Easily catch cold * Low energy * Feel worse after exercise   Heart function   * Palpitations * Anxiety * Sores on tip of tongue * Restlessness * Mental confusion * Chest pain traveling to shoulder * Frequent dreams * Wake unrefreshed * Coffee drinking ? |
| Spleen, stomach, Large Instestine, Small intestine function   * Loose stools * Constipated * Incomplete stool evacuation * Diarrhea * Blood in stool * Mucous in stool * Undigested food in stool   Liver Blood (LR, SP, HT fct)   * Dizziness * See floating spots * Frustration/Anger prominent emotion | Lung function   * Nasal discharge (color: ) * Cough * Nosebleeds * Snoring * Dry mouth * Dry throat * Dry skin * Allergies : to what? * Alternating chills and fever * Sneezing * Headach * Overall achy in whole body * Stiff neck * Stiff shoulders * Sore throat * Difficulty breathing * Smoking (risk) * Sadness/Melancholy |

|  |  |
| --- | --- |
| Spleen function   * Low appetite * Abrupt weight gain * Abrupt weight loss * Abdominal bloating * Abdominal gas * Gurgling in the stomach * Prolapsed organs : Which? * Easily bruised * Hemorrhoids * Pensive/over-thinking/worry | Stomach Function   * Burning sensation after eating * Large appetite * Low appetite * Bad breath * Mouth (canker) sores * Bleeding, swollen, painful gums * Heartburn * Acid reflux * Ulcer (diagnosed) * Belching * Hiccups * Stomach pain * Vomiting/Nausea |
| Liver, Gall Bladder Function   * Alternating diarrhea/constipation * Chest pain * Tight sensation in chest * Bitter taste in mouth * Anger easily * Frustration * Depressioni * Irritability * Difficulty adapting to stress? What causes the stress? * Skin rashes * Headache at top of head * Tingling in limbs * Numbness in limbs * Muscle spasms/cramping * Muscle twitching/Restless * Seizures/Convulsions * Feels like Lump in the throat * Neck tension/Limited motion * Shoulder tension/Limited motion * High-pitched ringing in ears * Gall stone history * STDs? | Dampness trapped in body   * General feeling of heaviness in body * Mental heaviness * Mental Fogginess * Swollen hands * Swollen feet * Swollen joints * Chest congestion * Nausea * Sinus congestion   Eyes (Liver Function)   * Itchy * Bloodshot * Hot * Dry * Watery * Gritty * Blurry visioni * Decreased night vision * Near-sighted or Far sighted |

|  |  |
| --- | --- |
| Kidney, Bladder Function   * Frequent cavities * Easily broken bones, osteoporosis * Sore /weak knees * Cold sensation in knees * Low back pain * Memory problems * Excessive hair loss * Low-pitched ringing in ears. * Kidney stones * Bladder infections * Wake in night 2X or more to urinate * Lack of bladder control * Fear a prominent feeling * Easily startled   Libido (Sexual energy)   * Normal * Low * High * Other symptoms   **Men Only:**   * Swollen testes (severe, moderate, slight) * Testicular pain * Impotence * Premature ejaculation * Loss of erection (ED) * Feeling of coldness or numbness in external genitatlia * Other | Urination   * Pale * Straw color (normal) * Dark yellow * Clear * Reddish * Scanty * Profuse * Strong odor * Burning * Painful * Discharge * Urgent * Frequent   **WOMEN only**  Regular menstrual cycle? Days of flow:  Days for entire cycle:  Clots?  Bleeding between periods.  Color of blood : bright red, normal, dark  Flow (normal, heavy, light)  Number children?  Number pregnancies  Age of menopause  Vaginal discharge? Color: Odor  Premenstrual symptoms?  Nausea  Food craving  Depression  Headaches ‘  Pain (dull, Sharp, crampy?) |
|  |  |

Other information

Patient e signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_