[](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***

www.janbullacupuncture.com

**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
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|  |  |
| --- | --- |
| 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 pregnanciesAge of menopauseVaginal discharge? Color: OdorPremenstrual symptoms? NauseaFood cravingDepressionHeadaches ‘Pain (dull, Sharp, crampy?) |
|  |  |

Other information

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