Resonance Acupuncture

Angela Cara Linamen, LAc, LMP

Health Intake Form

Thank you for taking the time to take care of your self!

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please answer the following questions as completely as possible. The information you provide will help me create a quality treatment specified to your individual needs. All your answers are completely confidential.

NAME ____________________ DATE __________

ADDRESS ____________________ CITY __________ STATE __________ ZIP __________

PHONE # ____________________ DATE OF BIRTH ____________________ GENDER M / F

EMAIL ____________________ Who should we thank for referring you? ____________________

EMERGENCY CONTACT ____________________

ADDRESS ____________________ PHONE # ____________________

PRIMARY CARE PHYSICIAN ____________________

ADDRESS ____________________ PHONE # ____________________

Where and when did you last receive health care? ____________________

____

For what reason? ____________________

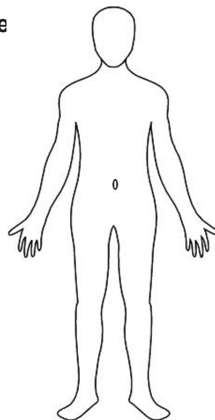
Have you ever received? Y / N Acupuncture Y / N Massage Y / N Craniosacral Therapy

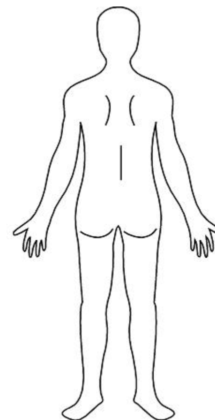
Please list your health concerns in their order of importance to you.
(including *Cause of the concern *Date first noticed it *Previous diagnosis *How it affects you)

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Please indicate where your symptoms are occurring and describe the

____
____
____
____
____





What makes your condition better? ____________________

____

What makes you condition worse? ____________________

____

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HEALTH INTAKE FORM (continued)

Allergies / Intolerances (chemical, environmental, food, drugs) **and their adverse effects** ____________

____

Surgeries / Serious illnesses / Injuries / Significant trauma (physical/emotional) ____________

____

Please list all supplements, prescriptions, non-prescription drugs, and their dosage:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Exercise: Days per week: Length of work out: Activity :

____

____

Spiritual Practice: ____

Typical Diet: (any restrictions?) ____

Breakfast ____

Morning snack ____

Lunch ____

Afternoon snack ____

Dinner ____

Late night snack ____

Describe your appetite: morning____________ noon____________ evening ____________

Alcohol____________ Cigarettes____________ Caffeine____________ Recreational Drugs ____________

How much water do you drink per day? ____

Are you satisfied with your diet as it is now? ____

Sleep: Do you sleep well?____________ Average hours of sleep? ____________ Easy to fall asleep?____________

Wake rested? ____________ Wake during the night? ____________ How many times? ____________

____

Occupation: ______________________________ Do you enjoy your work? ____________

Work activity: (please circle) sitting standing light labor heavy labor

Do you have any reason to believe that you are pregnant? Y/N

If you could change one habit, that would make all the difference in reaching your full potential, what would it be? ____________

____

Describe your passions in life? ____

____

What goals do you have for your visit today? ____

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HEALTH INTAKE FORM (continued)

Review of systems Please circle:

Y for a condition you have now
P for a condition you have had in the past
N if you've never had this condition

GENERAL

do you tend to be hot / cold				strong thirst	Y	P	N	sudden energy drop/time of day______			
sweat easily	Y	P	N	night sweats	Y	P	N	fatigue	Y	P	N
peculiar tastes/smells	Y	P	N	edema	Y	P	N	chronic infections	Y	P	N
fever	Y	P	N	change in appetite	Y	P	N	slow wound healing	Y	P	N
chills	Y	P	N	weight gain / loss	Y	P	N	bleed /bruise easily	Y	P	N

other ____

SKIN and HAIR

rashes / hives	Y	P	N	warts /growths	Y	P	N	face flushing	Y	P	N
eczema / psoriasis	Y	P	N	itching	Y	P	N	loss of hair	Y	P	N
acne	Y	P	N	recent moles	Y	P	N	change in skin/hair/nail	Y	P	N
skin discoloration	Y	P	N	fungal infection	Y	P	N	dandruff	Y	P	N

other ____

HEAD, EAR, NOSE and THROAT

eye strain / pain	Y	P	N	ringing in ears	Y	P	N	nose bleeds	Y	P	N
color blindness	Y	P	N	poor hearing	Y	P	N	sinus congestion	Y	P	N
eye dryness	Y	P	N	ear aches	Y	P	N	nasal drainage	Y	P	N
cataracts / glocoma	Y	P	N	discharge from ears	Y	P	N	headaches	Y	P	N
poor vision / glasses	Y	P	N	swollen glands	Y	P	N	migraines	Y	P	N
spots in front of eyes	Y	P	N	sore throats/colds(often)	Y	P	N	facial pain /twitch	Y	P	N
night blindness	Y	P	N	hoarseness	Y	P	N	grinding teeth	Y	P	N
sores on lips / tongue	Y	P	N	other____________________				jaw clicks	Y	P	N

CARDIOVASCULAR

low/high blood pressure	Y	P	N	palpitations at rest	Y	P	N	fainting	Y	P	N
swelling of hands / feet	Y	P	N	irregular heart beat	Y	P	N	varicose veins	Y	P	N
cold hands / feet	Y	P	N	blood clots	Y	P	N	chest pain / pressure	Y	P	N

What was your most recent blood pressure reading? ____________________ other____________________

RESPIRATORY

cough	Y	P	N	cough blood	Y	P	N	production of phlegm / color__________			
asthma / wheezing	Y	P	N	emphysema	Y	P	N	bronchitis	Y	P	N
difficulty breathing	Y	P	N	pleurisy	Y	P	N	pneumonia	Y	P	N
pain with deep inhalation	Y	P	N	difficulty breathing (lying down)	Y	P	N				

other ____

GENITO-URINARY

pain w/urination	Y	P	N	color of urine----------------------------------				sores on genitals	Y	P	N
urgency to urinate	Y	P	N	wake to urinate/# of times____________				pain in testicles	Y	P	N
frequency of urination	Y	P	N	urinary tract infection	Y	P	N	premature ejaculation	Y	P	N
blood in urine	Y	P	N	dribbling	Y	P	N	nocturnal emission	Y	P	N
decreased flow	Y	P	N	kidney stones	Y	P	N	impotency	Y	P	N
unable to hold urine	Y	P	N	change in libido	Y	P	N	other____________________			

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N if you've never had this condition

GASTROINTESTINAL

nausea /vomiting	Y	P	N	constipation	Y	P	N	# of bowel movements/day ________			
indigestion / heartburn	Y	P	N	diarrhea	Y	P	N	hemorrhoids	Y	P	N
bloating / gas	Y	P	N	chronic laxative use	Y	P	N	poor appetite	Y	P	N
belching	Y	P	N	black stools	Y	P	N	gall bladder disease	Y	P	N
bad breath	Y	P	N	rectal pain	Y	P	N	liver disease / hepatitis	Y	P	N
acid reflux / GERD	Y	P	N	hernia	Y	P	N	difficulty swallowing	Y	P	N
abdominal pain/cramps	Y	P	N	blood in stools	Y	P	N	IBS/chrohns	Y	P	N

other ____

GYNECOLOGICAL

age at first menses__________				painful periods	Y	P	N	polycystic ovarian disease	Y	P	N
date of last menses__________				irregular or no periods	Y	P	N	fibrocyctic breast tissue	Y	P	N
days b/w periods__________				nipple discharge	Y	P	N	uterine fibroids	Y	P	N
days of bleeding__________				menopause age__________				endometriosis	Y	P	N
heavy or light periods				color of blood__________				difficulty conceiving	Y	P	N
clots/size__________				uterine bleeding	Y	P	N	difficult or painful intercourse	Y	P	N
PMS symptoms / describe__________								vaginal discharge/dryness	Y	P	N

other ____

Do you practice birth control? Y / N what type? __________ how long? __________

# of pregnancies __________ # of live births__________

MUSCULOSKELETAL

neck pain	Y	P	N	hip pain	Y	P	N	carpal tunnel	Y	P	N
shoulder pain	Y	P	N	foot/ankle pain	Y	P	N	tendonitis	Y	P	N
back pain (upper)	Y	P	N	muscle weakness	Y	P	N	fractures / broken bones	Y	P	N
back pain (lower)	Y	P	N	muscle pain / spasm	Y	P	N	herniated disk	Y	P	N
elbow pain	Y	P	N	sprains / strains	Y	P	N	osteoporosis	Y	P	N
hand/wrist pain	Y	P	N	sciatica	Y	P	N	whiplash	Y	P	N
knee pain	Y	P	N	bursitis	Y	P	N	other__________			

NEURO PSYCHOLOGICAL

seizures / tremors	Y	P	N	lack of coordination	Y	P	N	easily susceptible to stress	Y	P	N
numbness/weakness	Y	P	N	poor balance	Y	P	N	depression	Y	P	N
sleep disorder	Y	P	N	poor memory	Y	P	N	anxiety / panic attack	Y	P	N
concussion	Y	P	N	ADD/ADHD	Y	P	N	seasonal affective disorder	Y	P	N
bad temper/violent	Y	P	N	vertigo / dizziness	Y	P	N	eating disorder	Y	P	N

other ____

In general how do you feel emotionally? __________________________

Have you ever considered or attempted suicide? Y / N

Have you ever been treated for emotional problems? Y / N

Have you ever been treated for substance abuse? Y / N

COMMENTS Please inform me of anything else that you would like to discuss? __________________________

____

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HEALTH INTAKE FORM (continued)

Please check if you are currently experiencing any of the following conditions?

______ Contagious disease ______ Flu/Cold ________ Inflammation

________ Fever ______ Infection ________ Pregnancy

Personal And Family History

Please describe any that apply **C** = current **P** = past

	Personal History	Family History		Personal History
Diabetes			Chronic pain	
Heart Disease			Chronic Fatigue	
Cancer			Fibromyalgia	
Hypertension			Anemia	
Asthma/Allergies			Headache	
HIV/AIDS			Hepatitis	
Mental Illness			Pacemaker	
Autoimmune disorders			Hypoglycemia	
Stroke			Ulcer	
Hereditary Disorders			Seizures	
Neurological Disorders			Tumors/growths	
Arthritis			STD's	
Endocrine imbalance			Thyroid disorder	
Osteoporosis			Gastrointestinal Disorders	

PLEASE READ and SIGN

I have completed this health intake form to the best of my knowledge and the above information is complete and correct. I understand that it is my responsibility to inform my health care provider whenever I have a change in health. I understand that services do not take the place of a physician's care when indicated and do not take the place of medical care, medical examination or diagnosis. I understand that Angela Linamen LAc LMP does not diagnose ailments.

I understand that massage therapy and bodywork services are a therapeutic health aid and are non-sexual. The following are contra indications for massage; or should be consulted by your physician first: acute infectious diseases, skin rashes, burns, infections and/or open wounds, atherosclerosis, embolism or thrombus thrombophlebitis (blood clotting), some cancers, fever, heart attack (massage is OK only after complete recovery), herpes (herpes is highly contagious when active; lesions can break out on arms, legs and back-massage is ok when there are no visible lesions) high risk pregnancy, diabetes with vascular dysfunction, bursitis, artificial blood vessels, and tendon or muscle ruptures. If you are going to be treated with Craniosacral Therapy please report acute aneurysm, cerebral hemorrhage or other preexisting severe bleeding disorders before treatment. If you have been diagnosed or are experiencing any of the above, please indicate on the intake form and tell the therapist.

I clearly understand that acupuncture and massage therapy are my personal financial responsibility and I agree to pay for services at the time of treatment at a time of service discount unless other arrangements have been made. Only Cash and Checks are accepted.

Cancellation Policy: I understand that if I cancel an appointment with less than 24 hours notice a $40 fee will be charged or fail to show up for an appointment an $85 fee will be charged directly to me.

Patient signature ____ Date ____________________

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