ABBOTT FAMILY CHIROPRACTIC, PC

DR. SIOBHAN A. CONKLYN, DC
4856 George Washington Memorial Hwy. – HAYES, VA 23072
(804) 832-6705

ACUPUNCTURE INTAKE FORM

Name: _____ File #: _____ **Date:** _____

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds
□ Pregnancy (certain or possible)

Please indicate the use and frequency of the following:

Coffee _____
Soda _____
Water _____
Alcohol _____
Recreational drugs _____
Tobacco _____

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

Medication **Dosage** **Reason**

_____
_____
_____
_____
_____

Health History:

What are the health problems for which you are seeking treatment?

_____
_____

How long have you had this condition?

_____
_____

What other forms of treatment have you sought?

_____
_____

What helps your condition?

_____
_____

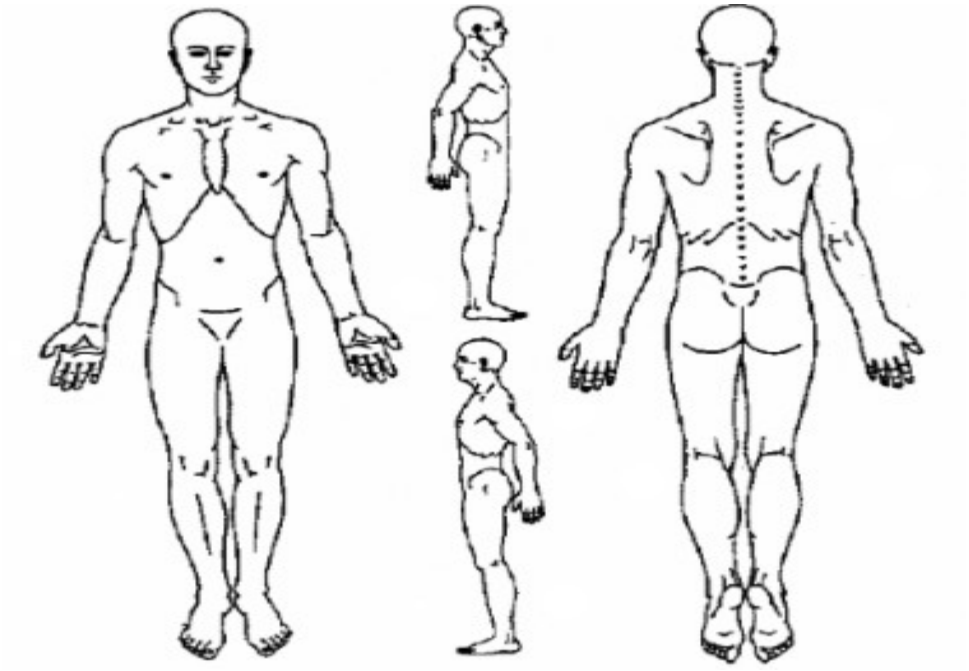
What aggravates your condition?

_____
_____

Please list any surgeries or major health incidents (accidents, etc.) in your life:

_____
_____
_____
_____

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain:
□ Dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

What would you like to achieve with acupuncture treatment?

_____
_____
_____

Are you interested in additional health services besides acupuncture? □ Yes □ No
Please check which services you might be interested in: □ Chiropractic □ Chinese Herbal Medicine
□ Therapeutic Massage □ Assisted Stretching/Yoga □ Relaxation techniques
□ Other _____

SYMPTOM SURVEY
Please "check" the symptoms or conditions your experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
__excessive appetite	__ insomnia	__ cough	__ low back pain	__ eye problems
__ loose stool/diarrhea	__ palpitations	__ shortness of breath	__ knee problems	__ jaundice
__ digestive problems/ indigestion	__ cold hands & feet	__ decreased sense of smell	__ hearing impairment	__ difficulty digesting oily foods
__ vomiting	__ nightmares	__ nasal problems	__ ear ringing	__ gall stones
__ belching, burping	__ mentally restless	__ skin problems	__ kidney stones	__light-colored stool
__heartburn/reflux	__ laughing for no reason	__ claustrophobia	__ decreased sex drive	__ soft or brittle nails
__ stomach bloating	__ chest pains	__ colitis/diverticulitis	__ hair loss	__ easily angered
__ obsession in work	__ poor memory	__ constipation	__ urinary problems	__ difficult relationships
__ blood in stool	__ sadness	__ allergies	__ dental problems	__ difficulty making decisions
__ lack of appetite	__ Depression	__asthma	__ fatigue	__dizziness
__ hemorrhoids	__ Anxiety	__ get sick easily	__edema	__headaches
__easily bruised				
__ I usually feel warm	__ I usually feel chilled			

Please indicate if the following pertain to you:
NOTE: This Symbol ♀: before a question, indicates that it is for Women only.

Kidney Yin Xu:
□ Do you have lower back weakness, soreness or pain?
□ Do you have ringing in your ears?
□ Is your hair prematurely gray?
□ Do you have dark circles under your eyes?
□ Do you have night sweats?
□ Are you prone to hot flashes?
□ Would you describe yourself as "afraid" frequently?
□ Do you have dizziness?
□ Do you have knee problems?
□ ♀: Do you have vaginal dryness?
□ ♀: Is your mid-cycle cervical mucus scanty or missing?

Kidney Yang Xu:
□ Is your back sore or weak?
□ Are your feet cold, especially at night?
□ Are you typically colder than those around you?
□ Is your libido low?
□ Are you often fearful?
□ Do you wake up at night or early in the morning because you have to urinate?
□ Do you urinate frequently, and is the urine diluted and/or profuse?
□ Do you have early morning loose, urgent stools?
□ ♀: Do you have low back pain pre-menstrually?
□ ♀: Do you have profuse vaginal discharge?
□ ♀: Do you feel cold cramps during your period that respond to a heating pad?

Spleen Qi – Xue – Yang Xu:
□ Are you often fatigued?
□ Do you have poor appetite?
□ Is your energy low after a meal?
□ Do you feel bloated after eating?

□ Do you crave sweets?
□ Do you have loose stools, abdominal pain, or digestive problems?
□ Are your hands and feet cold?
□ Are you prone to feeling sluggish?
□ Are you prone to heaviness or grogginess in the head?
□ Do you have varicose veins?
□ Are you prone to worry?
□ Have you been diagnosed with low blood pressure?
□ Do you sweat a lot without exerting yourself?
□ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
□ Are you often sick, or do you have allergies?
□ Have you ever been diagnosed with hypothyroid or anemia?
□ Do you have hemorrhoids or polyps?
□ ♀: Is your menstruation thin, watery, profuse, or pinkish in color?
□ ♀: Are you more tired around ovulation or menstruation?
□ ♀: Do you ever spot a few days or more before your period comes?
□ ♀: Have you ever been diagnosed with uterine prolapse?
□ ♀: Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

Blood Xu:
□ Do you have dry, flaky skin?
□ Are you prone to getting chapped lips?
□ Are your fingernails or toenails brittle?
□ Is your hair brittle or dry?
□ Do you have diminished nighttime vision?
□ Are your lips, the inner side of your lower eyelids, or tongue pale in color?
□ ♀: Do you get dizzy or light-headed around your period?
□ ♀: Are you losing hair on your head?
□ ♀: Are your menses scant or late?

Blood Stasis:
□ Do you experience periodic numbness of your hands and feet, especially at night?
□ Do you have varicose or spider veins?
□ Do you have red cherry spots (hemangiomas) on your skin?
□ Do you have chronic hemorrhoids?
□ Do you have dark spots in your eyes?
□ Have you been diagnosed with any vascular abnormality or blood clotting disorder?
□ ♀: Does your menstrual blood contain clots?
□ ♀: Have you been diagnosed with endometriosis or uterine fibroids?
□ ♀: Do you have piercing or stabbing menstrual cramps?
□ ♀: your menstrual flow ever brown or black in color?
□ ♀: Do you feel mid-cycle pain around your ovaries?
□ ♀: Do you have painful, unmovable breast lumps?

Liver Qi Stagnation:
□ Are you prone to emotional depression?
□ Are you prone to anger and/or rage?
□ Are your pupils usually dilated and large?
□ Do you have difficulty falling asleep at night?
□ Do you experience heartburn or wake up with a bitter taste in your mouth
□ ♀: Do you become irritable pre-menstrually?

□ ♀: Do you feel bloated or irritable around ovulation?
□ ♀: Does it feel as if your ovulation lasts longer than it should?
□ ♀: Are your breasts sensitive/sore at ovulation?
□ ♀: Do you experience nipple pain or discharge from your nipples?
□ ♀: Do you have a lot of pre-menstrual breast distension or pain?
□ ♀: Do you become bloated pre-menstrually?
□ ♀: Are your menses painful?
□ ♀: Do you feel your menstrual cramps in the external genital area?
□ ♀: Is your menstrual blood thick and dark, or purplish in color?

Heart:
□ Do you wake up early in the morning and have trouble getting back to sleep?
□ Do you have heart palpitations, especially when anxious?
□ Do you have nightmares?
□ Do you seem low in spirit or lacking vitality?
□ Are you prone to agitation or extreme restlessness?
□ Do you fidget?
□ Do you sweat excessively, especially on your chest?

Excess Heat:
□ Are your mouth and throat usually dry?
□ Are you often thirsty for cold drinks?
□ Do you often feel warmer than those around you?
□ Do you wake up sweating or have hot flashes?
□ ♀: Do you breakout with red acne, especially pre-menstrually?
□ ♀: Do you have a short menstrual cycle?
□ ♀: Do you have vaginal irritation?

Dampness:
□ Do you feel tired and sluggish after a meal?
□ Do you have cystic or pustular acne?
□ Do you have urgent, bright, or foul-smelling stools?
□ Are you overweight?
□ Do you have a wet, slimy tongue?
□ Does your body feel like a barometer? Can you sense when it will rain?
□ ♀: Does your menstrual blood contain stringy tissue or mucus?
□ ♀: Are you prone to yeast infections and vaginal itching?
□ ♀: Do you have fibrocytic breasts?

♀**For Women**:
Age of first period _____ Date of last period _____ # of children (live births) _____
Number of days between periods (your cycle) _____Number of days of flow_____

♀ **Check All that Apply:**
Color of flow: □ pale/light red □ red □ bright red □ dark red □ dark red/brown □ dark red/purple
# of pads you use per day: 1st day ___ 2ND day ___ 3RD day ___ 4th day ___ 5th day ___
Pain and Cramping: □ No /□ Yes □ mild □ moderate □ severe
1st day ___ 2ND day ___ 3RD day ___ 4th day ___ Before flow ___ After flow ___

Amount of flow:

□ even throughout

□ clots	□ No / □ Yes	1st day	___2ND day	__3RD day	___4th day	___Before flow	___After flow
□ spotting	□ No / □ Yes	1st day	___2ND day	__3RD day	___4th day	___Before flow	___After flow
□ light	□ No / □ Yes	1st day	___2ND day	__3RD day	___4th day	___Before flow	___After flow
□ heavy	□ No / □ Yes	1st day	___2ND day	__3RD day	___4th day	___Before flow	___After flow

Other symptoms related to menses: □ Discharge □ PMS □ Headache □ Nausea □ Constipation □ Diarrhea □ Swollen Breasts □ Mood Swings □ Increased Appetite □ Decreased Appetite □ Insomnia

Have you ever been diagnosed with: □ fibroids □ fibrocystic breasts □ endometriosis □ ovarian cysts □ PID □ polycystic ovary syndrome □ STD _____

Fertility Information:

# of IVF procedures_____

# of IUI procedures_____

Has a physician diagnosed a difficulty with fertility due to: □ Female Factor □ Male Factor □ Unexplained

□ Other _____