Patient Intake Form

Please take the time to fill this form out. It will help me to determine how best to treat you. Thank you!

Dina M. Singer, L.Ac.

Patient Information:

Name: _____Date:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Email address:_____

Telephone:
*Cell: _____
*Home: _____
*Work: _____
Which phone number is the best one to use to reach you?_____

Height: _____Weight:_____Occupation:_____

Emergency Contact/relationship to you: _____

Emergency Contact telephone: _____

Name of physician*: _____

Physician telephone number: _____

Name of counselor/psychologist*: _____

Counselor/psychologist telephone number: _____
*No contact will be made without your permission.

What has brought you to acupuncture? Please list all concerns, issues, ailments or conditions that you would like to address during treatment.

_____
_____
_____
_____
_____

Personal lifestyle habits: For each item, please indicate how much, how many, or how often.

Cigarettes (single or packs per day): _____
Alcohol (drinks per week):_____
Drug use (recreational): _____
Coffee/Tea (cups per day): _____
Soda (regular or diet) (how many per day): _____
Exercise: Yes or No and how often: _____
What kind of exercise? _____

Medical: If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list them below along with the year.

_____
_____
_____
_____

Medications, vitamins, and supplements: Please list all medications, vitamins and/or food supplements you are currently taking.

***Please include dosage and reason/for what condition.

_____
_____
_____
_____
_____
_____

Current and Past Conditions/Symptoms/Traumas

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of these in the past, please mark it with a "P".

Mental/Emotional
__Depression
__Mood swings
__Irritability
__Difficulty relaxing
__Sensitive
__Frequent Worrying
__Frequent Crying
__ Hopeless Outlook
__Lose temper
__Frustration/Anger
__Other(describe)
_____

Cardiovascular
__High blood pressure
__Low blood pressure
__Chest pain/tightness
__Rapid heartbeat

Gastrointestinal
__Constipation
__Indigestion/Reflux
__Diarrhea
__Gas/Bloating
__Stomach pain
__Vomiting
__Other(describe)
_____

Nose, Throat and Mouth
__Frequent sinus infections
__Allergies
__Cold sores, mouth ulcers
__Frequent colds
__Excessive phlegm
__Difficulty swallowing
__TMJ

Head & Neck
__Headaches
__Migraines
__Stiff Neck
__Dizziness/Vertigo
__Fainting
__Other(describe)
_____

Sleep
__Insomnia
__Dreams/Nightmares
__Trouble falling asleep
__Racing thoughts
__Chronic fatigue
__Poor memory
__Night sweats
__Other(describe)
_____

__Poor circulation
__Joint pain/swelling
__Swollen ankles
__Anemia
__History of heart disease
__Heart murmur
__Tendency to be cold
__Tendency to be warm
__Other(describe)
_____

Skin
__Eczema/psoriasis
__Easily bruises
__Dry skin
__Itchy skin
__Excessive sweating
__Other(describe)
_____

Ears
__Ringing/Tinnitus
__Hearing loss/aids
__Infections
__Earaches
__Other(describe)
_____

Male genital
__Impotence
__Decreased libido
__Other(describe)
_____

Other information (list)
_____
_____
_____
_____
_____
_____

Neurological

__Seizures
__Tremors
__Numbness/Tingling
__Poor coordination
__Other(describe)
_____

Urinary
__Frequent urination
__Urgent urination
__Painful urination
__Frequent UTI's
__Kidney issues
__Other(describe)
_____

Eyes
__Glasses/Contacts
__Blurred vision
__Poor night vision
__Spots or floaters
__Glaucoma
__Cataracts
__Lazy eye
__Other(describe)
_____

Trauma(list)
_____
_____
_____
_____
_____

Musculoskeletal

__Sore muscles
__Weak muscles
__Difficulty walking
__Limited range of motion
__Other(describe)
_____

Respiratory
__Difficulty breathing
__Asthma
__Chronic cough
__Shortness of breath
__Tight chest
__Other(describe)
_____

Female gynecology
__Currently pregnant
__# of pregnancies
__# of live births
__# of miscarriages
__# of abortions
__Menopause
__Irregular periods
__Menstrual cramps
__Excessive blood flow
__Menstrual blood clots
__Vaginal infections
__Vaginal pain/itching
__Uterine fibroids
__Endometriosis
__Decreased libido

Patient Name_____

Patient Signature_____

Date_____