Debra, J. Bebell, A.P.

acupuncture
patient intake form

Confidential Patient Information

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Please list the telephone number you wish to receive calls about your appointments, or other health related information if different than your home phone number: _____

Marital Status: _____ Profession: _____

Company Name and Work Address: _____

_____

Birth Date: _____ Age: _____ Sex: ○ Male ○ Female

Who can we contact in an emergency? (Name) _____

(Phone) _____

How are you related to this person? _____

Please list any family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____

Can confidential messages (appointment reminders, etc.) be left on your home phone answering machine or voicemail? ○ Yes ○ No Please indicate if you want all correspondence from our office sent in a sealed envelope marked "Confidential": ○ Yes ○ No

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if different than the above: _____

_____

How did you hear out about i spa?

Referral _____, internet, yellow pages, other _____

May we add you to our monthly e-mail newsletter list, filled with health tips, information about our upcoming events and other valuable health related resources? ○ Yes ○ No

Medical History

Please check conditions/symptoms that you currently experience:

General
____Poor appetite
____Appetite change
____Heavy appetite
____Night sweats
____Cold hands/feet
____Peculiar tastes
____Fatigue
____Local weakness
____Sweat easily
____Strong thirst
____Poor sleep
____Heavy sleep
____Fevers
____Chills
____Tremors
____Poor coordination
____Bone/Joint problems
____Dizziness
____Bruise/bleed easily
____Pain

Eyes, Ears, Nose, Throat
____Migraines
____Headaches
____Wear glasses
____Eye strain
____Eye pain
____Poor vision
____Night blindness
____Blurry vision
____Cataracts
____Earaches
____Poor hearing
____Ringing in ears
____Nose bleeds
____Sinus problems
____Mucus
____Dry throat/mouth
____Grinding teeth
____Excess saliva
____Teeth problems
____Jaw clicks/pain
____Sore throats
____Face pain
____Gum problems
____Lip/tongue soars
____Other Ear/Eye/Nose/Throat:

_____

Cardiovascular:
____Chest pain
____Fainting
____Blood clots
____Difficulty breathing
____Palpitations
____Phlebitis
____Hand/foot sweating
____Irregular heartbeat
____Other cardiovascular problems:

_____

Lung/Respiratory:
____Cough
____Coughing blood
____Phlegm
____Asthma
____Bronchitis
____Pneumonia
____Chest Tightness
____Difficulty breathing when laying down
____CPAP machine at night
____Other respiratory problems:

_____

Gastrointestinal
____Nausea
____Vomiting
____Diarrhea
____Constipation
____Gas
____Belching
____Bad breath
____Rectal pain
____Abdominal pain/cramps
____Black stools
____Blood stools
____Hemorrhoids
____Laxative Use
____Ulcers
____Other Gastrointestinal problems:

_____

Date of last GI Scope:

_____

Skin/Hair
____Rashes
____Hives
____Itching
____Ulcerations
____Eczema
____Pimples
____Dandruff
____Hair Loss
____Hair/skin changes
____Bruises
____Other skin/hair problems:

_____

Genito-Urinary
____Painful urination
____Blood in urine
____Urgent urination
____Frequent urination
____Incontinence
____Urinary retention
____Kidney stones
____Impotency
____Venereal disease
____Premature ejaculation
____Wake to urinate
____Other genito-urinary problems:

_____

Neurological/Psychological
____Numbness
____Poor memory (short or long term)
____Depression
____Anxiety
____Bad temper
____Considered/Attempted suicide
____Concussion
____Easily stressed
____Treated for emotional problems
____Other Neurological/ Psychological:

_____

Medical History

Please circle all conditions/symptoms that apply to you:

Head:

Headaches: Mild Moderate Severe
How often? (1 2 3 4 5 6 7) times Per (day week month)
Are they: Sharp Dull Are they: Constant Intermittent
Where are they located: Back of head Forehead Temples Right Side Left Side Behind the eyes
Do you experience any of the following: Light headed Memory loss Blurred vision Double vision
Loss of balance Sensitivity to light Fainting Hearing loss

Neck:

Pain: Left side Right side Both Pain level: Mild Moderate Severe
Pain increased by: Forward movement Backward movement Rotation of head to left
Rotation of head to right Bending head to left Bending head to right Stiffness
Muscle spasms Grinding/Grating sounds

Shoulders:

Pain in joint: L R Both
Pain across shoulders: L R Both
Limitation of movement: L R Both
Tension: L R Both

Chest:

Deep chest pain: L R Both
Pain level: Mild Moderate Severe
Pain around ribs: L R Both
Shortness of breath: Y N
Irregular heartbeat: Y N

Feet:

Ankle pain: L R Both
Swollen ankles: L R Both
Foot pain: L R Both
Numbness of feet: L R Both
Swollen feet: L R Both
Foot cramps: L R Both

Arms:

Pain in upper arm: L R Both
Pain in elbow: L R Both
Pain in forearm: L R Both
Tingling in arm: L R Both
Tingling in forearm: L R Both
Numbness in arm: L R Both
Numbness in forearm: L R Both

Hands:

Pain in wrist: L R Both
Pain in hands: L R Both
Tingling in hands: L R Both
Numbness in hands: L R Both

Midback:

Pain: L R Both
Pain level: Mild Moderate Severe
Pain type: Sharp/Stabbing Dull/aching
Muscle spasm: L R Both

Low Back:

Upper lumbar pain: L R Both
Lower lumbar pain: L R Both
Sacro-Iliac pain: L R Both
Muscle spasms: L R Both
Pain level: Mild Moderate Severe

Hips and Legs:

Pain in buttocks: L R Both
Pain level: Mild Moderate Severe
Pain in hip joint: L R Both
Pain level: Mild Moderate Severe
Pain down leg: L R Both
Location: Front Back Side
Radiates to: Knee Calf Toes
Numbness down leg: L R Both
Location: Front Back Side
Tingling in leg: L R Both
Knee pain: L R Both
Leg cramps: L R Both

Medical History

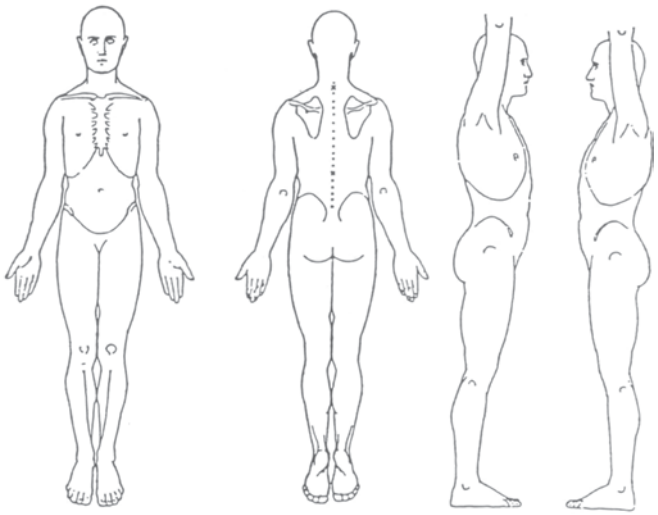
Are you taking any medications currently? If so, please list the name and dosages, if possible.
(Include all vitamins, herbal supplements, and over-the-counter medications.)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you have any allergies? (medication, food, other substance): If so, Please list and state the reaction you had: _____

_____

Please mark on the diagram any areas of pain and any scars that you may have:
X for pain
O for scar



Please list any surgeries you have had:

_____

_____

_____

Women:

Menstrual Periods: Age Onset _____ Are they Regular? ○ Yes ○ No

Average Cycle Length: _____ Date Last Period Began: _____

Difficulty with Periods? ○ Yes ○ No If yes, please specify: _____

Number of: Births _____ Premature Births _____ Miscarriages _____ Pregnancies _____

Describe Pregnancy or Other Complications (if applicable): _____

Date of last PAP smear: _____ Date of last breast exam: _____

Do you have any of the following: Breast lumps Vaginal Discharge Blood clots in menses

What type of birth control do you use? (if any): _____

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Physician Name: Debra J. Bebell, A.P.

Physician Signature: _____ Date: _____