Angela Bell Acupuncture
186 Alewife Brook Parkway, Suite 302
Cambridge, MA 02138

INITIAL INTAKE FORM

First Name: _____ MI:_____ Last Name:_____ Date _____

Address _____

City: _____ State: _____ Zip: _____

Phone: day _____ Eve _____ Cell:_____

Date of Birth _____/_____/_____

I will never sell or transfer your information to third parties. I would like to send you our newsletter or information by email. May I? ( ) Yes ( ) No May I by mail? ( ) Yes ( ) No

Email: _____

Gender: O Male O Female

Emergency Contact:_____ Contact Phone: _____

Primary Physician _____ Physician's Phone: _____

Referral Information (How did you hear about us?):

_____

CURRENT HEALTH

What are the main symptoms/problems you seek treatment for, and how long have you had them?

_____

_____

_____

_____

_____

_____

Diagnoses you've been given by physicians: _____

_____

_____

_____

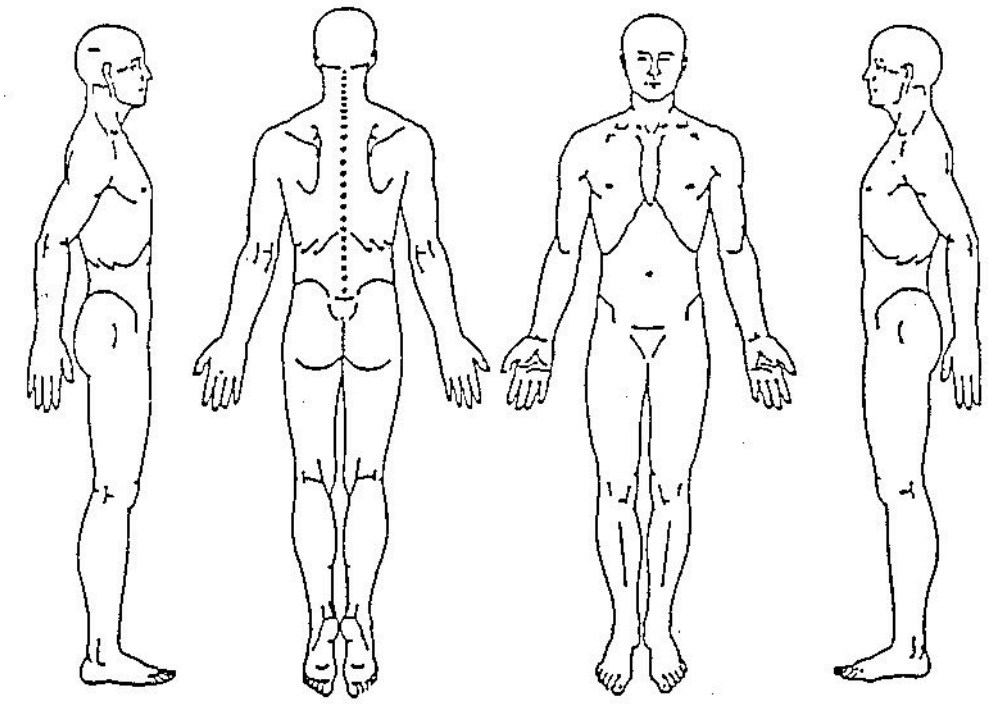
Have you had any treatment, surgery, or hospitalization for your main complaint?_____

_____

_____

_____

Please indicate any painful or distressed areas by circling the area.



WESTERN MEDICAL DIAGNOSIS

Please check off any Western Diagnosis you have now or have had in the past:

O Diabetes	O Stroke/heart attack	O Multiple sclerosis
O Epilepsy/ seizures	O Pacemaker	O Allergies to metal
O Arthritis	O Fibromyalgia	O Chronic fatigue syndrome
O Cancer: what type _____		Other:_____

O mental health issues: what type _____

_____

O HIV/AIDS O Hepatitis B O Hepatitis C O TB

O Allergies: what drugs or substances (plant, animal, environmental)_____

_____

DIAGNOSTIC QUESTIONS

Please indicate all symptoms below that you have experienced **within the past 30 days**.
Please circle according to the severity of your symptoms
L=Light M=Medium S=Strong
If you do not have the symptom, do not circle anything.

HEAD, EYES, EARS, NOSE, THROAT

L M S sinus problems
L M S nose bleeds
L M S dry mouth
L M S difficulty swallowing
L M S sore throat/mouth
L M S thrush/leukoplakia
L M S headaches
L M S dental/gum
L M S thirst
L M S ear/hearing problems
L M S vision problems
L M S dizziness
L M S sneezing/runny nose
L M S other (specify)_____

RESPIRATORY

L M S shortness of breath
L M S pain w/deep breath
L M S phlegm
L M S blood in sputum
L M S wheezing
L M S cough
L M S bronchitis
L M S frequent colds
L M S chest pain
L M S other (specify)_____

GASTROINTESTINAL

L M S loss of appetite
L M S abdominal cramps
L M S nausea
L M S gas/bloating
L M S constipation
L M S diarrhea
L M S weight loss
L M S hemorrhoids
L M S vomiting
L M S heartburn
L M S other, specify: _____
L M S jaundice
_____

CARDIOVASCULAR

L M S low blood pressure
L M S high blood pressure
L M S palpitations
L M S other, specify_____

GENITO-URINARY

L M S frequent urination
L M S night urination
L M S impotence
L M S low sex drive
L M S pain
L M S edema
L M S genital sores
L M S genital warts
L M S other, specify_____

MUSCULAR/SKELETAL

L M S muscle/joint pain
L M S back pain
L M S weakness
L M S pain, tingling or numbness in arms, legs, fingers, toes/ neuropathy
L M S stiff neck/shoulders
L M S other, specify _____

NEUROLOGICAL/PSYCHOLOGICAL

L M S depression	L M S anxiety	L M S fear
L M S irritability/anger	L M S disorientation	L M S forgetfulness
L M S tremors	L M S insomnia	L M S seizures
L M S poor concentration	L M S bipolar	

L M S other, specify _____

SKIN/HAIR/NAILS

L M S itchy/painful rashes	L M S fungus	L M S shingles
L M S psoriasis/eczema	L M S mole changes	L M S cold sores
L M S new KS	L M S hair loss	L M S acne
L M S bleed/bruise easily	L M S other _____	

OTHER SYMPTOMS

L M S fever over 100	L M S night sweats	L M S fatigue
L M S swollen lymph nodes	L M S chills	L M S day sweats
L M S glucose intolerance		

L M S other_____

GYNECOLOGICAL/OBSTETRICS (*Women Only*)

L M S yeast infections	L M S menstrual cramps	L M S clots
L M S pelvic infections	L M S spotting	L M S PMS
L M S mid-cycle pain	L M S irregular periods	L M S no periods
L M S vaginal discharge	L M S vaginal pain/itching	L M S hot flashes

L M S Other _____

Menstrual Info: _____ days bleeding _____ day cycle date last period _____

Please describe in more detail any menstrual problems you are experiencing: _____

_____

_____

_____

Do you take Hormone Replacement Therapy? O Yes O No

Are you pregnant? O Yes O No O Unknown

Please alert your practitioner if you become pregnant. Your treatment will be modified to support a healthy pregnancy.

Are you in menopause? O Yes O No O Unknown

How many pregnancies have you had? _____ Cesareans? _____

Date last pap smear _____ NORMAL ABNORMAL

Last breast exam _____ NORMAL ABNORMAL

WESTERN MEDICATIONS

Please list below all of the medications/supplements/herbs you currently take:

I do not take any O Western medications O Supplements O Herbs

Medication/Supplement/Herb Used to treat Side-Effects Experienced

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

Client Signature:_____**Date:**_____