

**Gloria Provitola, L.M.T.
Chi Nei Tsang Intake Form**

DATE: _____

PATIENT INFORMATION

Name: _____

Gender: _____

Age: _____ Date of Birth: ___/___/___ Social Security # _____ - _____ - _____

Home Address: _____

Home Phone: _____ Cell: Work Phone: _____

Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Occupation: _____

I. EXPERIENCE WITH ACUPUNCTURE

~ Have you received acupuncture treatment before? YES NO

~ If yes, for what conditions and what was the outcome?

II. MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Name of medication, supplement or herb	Taking this for what condition or purpose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

III. DESCRIPTION OF MAJOR COMPLAINTS

In order of priority What are your complaints?	Complaint 1	Complaint 2	Complaint 3
How long have you had this condition?			
Was the onset gradual or sudden?			
Was there a significant event that lead to this condition? Please answer Yes or No.			
Have you seen a physician or other primary care provider for this complaint? If yes, what diagnosis did you receive?			
Please check other therapies you receive(d) to manage each complaint? Which is helping or has helped?	Physical Therapy ____ Chiropractic ____ Massage ____ Other ____	Physical Therapy ____ Chiropractic ____ Massage ____ Other ____	Physical Therapy ____ Chiropractic ____ Massage ____ Other ____
Rate the intensity of the <i>PHYSICAL & EMOTIONAL DISCOMFORT</i> associated with each complaint (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)	PHYSICAL ____ EMOTIONAL ____	PHYSICAL ____ EMOTIONAL ____	PHYSICAL ____ EMOTIONAL ____
What relieves the symptoms of these complaints (e.g. heat, cold, pressure, movement, rest, etc)?	Heat ____ Cold ____ Pressure ____ Movement ____ Rest ____ Other ____	Heat ____ Cold ____ Pressure ____ Movement ____ Rest ____ Other ____	Heat ____ Cold ____ Pressure ____ Movement ____ Rest ____ Other ____
What makes the symptoms of your complaint worse?	Heat ____ Cold ____ Pressure ____ Movement ____ Rest ____ Other ____	Heat ____ Cold ____ Pressure ____ Movement ____ Rest ____ Other ____	Heat ____ Cold ____ Pressure ____ Movement ____ Rest ____ Other ____

V. PERSONAL MEDICAL HISTORY

A. BIRTH: Describe anything significant/traumatic about your birth:

B. VACCINATION HISTORY: Any unusual reaction? Any unusual vaccination?

C. CHILDHOOD ILLNESSES (0-12 years):

Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

AGE: _____

AGE: _____

D. ADOLESCENCE ILLNESSES & SURGERIES (13-17 years):

Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses & treatment, dates of surgeries & outcome.

AGE: _____
AGE: _____
AGE: _____
AGE: _____

E. ADULTHOOD ILLNESSES & SURGERIES (18 – 35 years): Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses & treatment, dates of surgeries & outcome.

AGE: _____
AGE: _____
AGE: _____
AGE: _____
AGE: _____

F. ADULTHOOD ILLNESSES & SURGERIES (36 & up): Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses & treatment, dates of surgeries & outcome. .

AGE: _____
AGE: _____
AGE: _____
AGE: _____

IV. FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER _____
FATHER _____
SIBLINGS _____
MATERNAL GRANDPARENTS _____
PATERNAL GRANDPARENTS _____

V. A. FOR WOMEN ONLY

(Please explain in the space provided if you have any of the following symptoms)

Abnormal vaginal bleeding _____
Changes in hair distribution _____
Fertility concerns _____
Irregular menstruation _____
Menopausal symptoms _____
Bone Density Decline _____
Vitamin D Deficiency _____
No menses _____
Pain with menses (dysmenorrhea) _____
Pain during or after sexual relations _____
Pelvic pain _____
Premenstrual symptoms _____
Sexual dysfunction _____
Unusual discharge _____

Are you pregnant OR trying to become pregnant?

YES NO (Circle one)

Have you ever been pregnant? YES NO (Circle one)

If yes, how many pregnancies: _____

Births _____

Miscarriages _____

Abortions _____

V. B. FOR MEN ONLY

Fertility concerns _____
Prostate problems _____
Sexual dysfunction _____
Unusual discharge _____
OTHER (Please list) _____

IV. Your Lifestyle

A. Do you smoke tobacco? YES NO (circle one) If yes, please describe amount and frequency of use.
_____ What impact do you believe
smoking has on your complaints? _____

A. Do you drink alcohol? YES NO If yes, please describe how much and under what circumstances you drink.
_____ What impact do you believe alcohol consumption has
on your complaints? _____

C. Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO
_____ What impact do you believe this has on your complaints? _____

VII. Diet and Nutrition

A. Briefly describe your eating habits and appetite, including any dietary restrictions or diet regimen. Number of meals and snacks per day?

VIII. Implants and Cosmetic Surgeries.

Do you have a pacemaker or any type of implant? Yes ____ No ____
What type and when was this implanted _____

Have you had any kind of cosmetic surgery or cosmetic implants? Yes ____ No ____
When and in what type _____

I have answered these questions to the best of my knowledge.

Signature _____ Date: _____