

# LaDue Acupuncture, LLC

## COMPREHENSIVE PATIENT INTAKE

Name \_\_\_\_\_ Date \_\_\_\_\_

*Natural healthcare is possible only when the practitioner completely understands the patient's physical, mental and emotional conditions. The information you provide helps your practitioner understand your needs and how to help you reach your health goals. Please answer each question completely. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

Address \_\_\_\_\_ Phone (H) \_\_\_\_\_

*(Note: Insurances will not use a PO Box as an address. Please provide a street address for all insurance billing.)*

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (W) \_\_\_\_\_

Email\* \_\_\_\_\_

\*Please register me for  VIDA Family Medicine Newsletter

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  Female  Male

Weight \_\_\_\_\_ Height \_\_\_\_\_ Are you Pregnant?  No  Yes, # of weeks? \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_

How were you referred? \_\_\_\_\_

Marital Status  Single  Married  Partnered

Separated  Divorced  Widowed

Partner/ Spouse Name \_\_\_\_\_

Number and ages of Children \_\_\_\_\_

Who is your Primary Care Doctor? \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit? \_\_\_\_\_ Reason for visit? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL QUESTIONNAIRE**

**HEALTH CONCERNS**

Please list all current health concerns that you would like to have addressed, in order of importance.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**CURRENT PRESCRIPTION MEDICATION** *(Attach additional sheet if necessary.)*

<u>Name</u>	<u>Dose</u>	<u>How Often</u>	<u>Reason</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

**CURRENT SUPPLEMENTS – Nutritional, Vitamins, Herbs, OTC.** *(Attach additional sheet if necessary.)*

<u>Name</u>	<u>Dose</u>	<u>How Often</u>	<u>Reason</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

**ALLERGIES**

<u>Medication/ Food/ Environment</u>	<u>What effect?</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**CURRENT HEALTH INDICATORS**

**Blood Pressure** \_\_\_\_\_ / \_\_\_\_\_ **Date of last check** \_\_\_\_\_ **By whom?** \_\_\_\_\_

**Cholesterol** HDL \_\_\_\_\_ LDL \_\_\_\_\_ Total \_\_\_\_\_ **Date of last check** \_\_\_\_\_

**PAST MEDICAL HISTORY**

**Major Illnesses (Including childhood illnesses):**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Major Injuries (Please give location of any scars):**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Hospitalizations and Surgeries (Please give month/year if possible):**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Contagious Diseases**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Emotional Trauma**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**FAMILY HISTORY**

	<b>Father</b>	<b>Mother</b>	<b>Brothers</b>	<b>Sisters</b>	<b>Spouse</b>	<b>Children</b>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good P=Poor)	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

**Check and note all that apply to each family member**

Cancer (type)	_____	_____	_____	_____	_____	_____
Diabetes (type)	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Hay Fever/ Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____

**OCCUPATIONAL HISTORY**

<b>Position Held</b>	<b>Type of Work</b>	<b># of Years</b>
Present _____		

Do you enjoy your work?       Yes       No

Previous \_\_\_\_\_

**HEALTHCARE MAINTENANCE**

<b>Test</b>	<b>Date</b>	<b>Result</b>	<b>Test</b>	<b>Date</b>	<b>Result</b>
Physical Exam	_____	_____	Breast Exam (Doctor)	_____	_____
Rectal Exam	_____	_____	Mammogram	_____	_____
Stool for Blood	_____	_____	Pap Smear/ Pelvic	_____	_____
Colonoscopy	_____	_____	Prostate/ Testicle	_____	_____
Sigmoidoscopy	_____	_____	PSA Blood Test	_____	_____
Eye exam/ Vision	_____	_____	MRI	_____	_____
Hearing Test	_____	_____	X-Ray	_____	_____
Dental Exam	_____	_____	Other	_____	_____

**HEALTH SYSTEMS**

Y = a condition you have now

P = a condition in the past

**GENERAL**

Fatigue Y P  
 Appetite Change Y P

**SKIN**

Dry Skin Y P  
 Rashes Y P  
 Eczema, Hives Y P  
 Acne, Boils Y P  
 Itching Y P  
 Color Change Y P  
 Lumps Y P  
 Night Sweats Y P  
 Pale Skin Y P

**HEAD**

Headache Y P  
 Head Injury Y P

**EYES**

Impaired Vision Y P  
 Eye Pain Y P  
 Dryness Y P  
 Double Vision Y P  
 Glaucoma Y P  
 Cataracts Y P

**NOSE & SINUS**

Frequent Colds Y P  
 Nose Bleeds Y P  
 Stuffiness Y P  
 Hay Fever Y P  
 Sinus Problems Y P

**MOUTH & THROAT**

Freq Sore Throats Y P  
 Sore Tongue Y P  
 Gum Problems Y P  
 Hoarseness Y P  
 Dental Cavities Y P

**NECK**

Lumps Y P  
 Swollen Glands Y P

Goiter Y P  
 Pain or Stiffness Y P

**RESPIRATORY**

Cough Y P  
 Sputum Y P  
 Spitting up blood Y P  
 Wheezing Y P  
 Asthma Y P  
 Bronchitis Y P  
 Pneumonia Y P  
 Pleurisy Y P  
 Emphysema Y P  
 Pain on breathing Y P  
 Tuberculosis Y P  
 Shortness of breath Y P

**BLOOD**

Anemia Y P  
 Bleed/Bruise Easily Y P

**EARS**

Impaired Hearing Y P  
 Ringing Y P  
 Earache Y P  
 Dizziness Y P  
 Vertigo Y P

**GASTROINTESTINAL**

Heartburn Y P  
 Thirst Change Y P  
 Nausea Y P  
 Vomiting Y P  
 Loose stool Y P  
 Diarrhea Y P  
 Blood in Stool Y P  
 Gas/Bloating Y P  
 Constipation Y P

**MUSCULOSKELETAL**

Joint Pain Y P  
 Joint Stiffness Y P  
 Arthritis Y P

Broken Bones Y P  
 Muscle Spasms Y P  
 Weakness Y P

**PERIPHERAL VASCULAR**

Deep Leg Pain Y P  
 Cold Hands/Feet Y P  
 Varicose Veins Y P

**EMOTIONAL**

Depression Y P  
 Mood Swings Y P  
 Anxiety Y P  
 Suicidal Y P

**NEUROLOGIC**

Fainting Y P  
 Seizures Y P  
 Paralysis Y P  
 Muscle Weakness Y P  
 Numbness/ Tingling Y P  
 Concentration Prob Y P  
 Loss of Memory Y P

**URINARY**

Pain on urination Y P  
 Increased frequency Y P  
 Frequency at night Y P  
 Inability to hold urine Y P  
 Frequent infections Y P

**ENDOCRINE**

Hypothyroid Y P  
 Heat/Cold Intolerance Y P  
 Excessive Thirst Y P  
 Excessive Hunger Y P  
 Hypoglycemia Y P  
 Low Blood Pressure Y P  
 Sugar Cravings Y P  
 Weight Gain  
 \_\_\_\_\_ lbs over \_\_\_\_\_ years

**CARDIOVASCULAR**

Heart Disease Y P  
 Angina Y P  
 High Blood Pressure Y P  
 Heart Murmur Y P  
 Rheumatic Fever Y P  
 Chest Pain Y P  
 Swelling in ankles Y P  
 Palpitations Y P

**MALE REPRODUCTIVE**

Hernias Y P  
 Testicular mass Y P  
 Testicular pain Y P  
 Sexually active Y P  
 Sexual difficulties Y P  
 Prostate disease Y P  
 STDs Y P  
 Discharge Y P  
 Sores Y P  
 Diminished sex drive Y P  
 Erectile dysfunction Y P

**FEMALE REPRODUCTIVE**

Age Menses Began \_\_\_\_\_  
 Average # of days \_\_\_\_\_  
 Length of cycle \_\_\_\_\_  
 Spotting Y P  
 Painful Intercourse Y P  
 Painful Menses Y P  
 Excessive Flow Y P  
 Birth Control Y P  
 What type? \_\_\_\_\_  
 # of Pregnancies \_\_\_\_\_  
 # of Live Births \_\_\_\_\_  
 # of Miscarriages \_\_\_\_\_  
 # of Abortions \_\_\_\_\_  
 Difficulty Conceiving Y P  
 Sexually Active Y P  
 Diminished Sex drive Y P  
 Sexual Difficulties Y P  
 STDs Y P  
 PMS Y P

Irregular Periods Y P  
 Menopausal Y P  
 When did menses stop?  
 \_\_\_\_\_  
 Decreased Vaginal Lubrication Y P  
 Day/Night Sweats Y P  
 Hot Flashes Y P  
 Nipple Discharge \_\_\_ One breast  
 \_\_\_ Two breasts  
 Have you ever had  
 Hysterectomy Y  
 When? \_\_\_\_\_  
 Ovaries removed Y  
 When? \_\_\_\_\_  
 Tubal Ligation Y  
 When? \_\_\_\_\_

**TYPICAL DIET**

**Breakfast:** \_\_\_\_\_

**Lunch:** \_\_\_\_\_

**Dinner:** \_\_\_\_\_

**Snacks:** \_\_\_\_\_

**Dietary Restrictions:** \_\_\_\_\_

**I certify that the information that I have supplied is correct and accurate to the best of my knowledge.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_