# Client Intake Form

**Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. It may take 15-20 to complete. All your information will be confidential. If you have questions, please ask. Thank you.**

| | | | | |
|---|---|---|---|---|
| Full name: | | | | Today's Date: |
| Date of birth: | Age: | Birth Sex: ☐ F ☐ M | Has it changed? ☐ Yes ☐ No | |
| Height: | Weight: | Occupation: | | |
| Primary phone #: | | Secondary phone #: | | |
| E-mail address: | | | Allow email contact? ☐ Yes ☐ No | |
| Street Address: | | City: | State: | Zip: |
| Emergency contact name & phone #: | | | | |
| Primary physician: | | | | |
| Do you have health insurance? ☐ Yes ☐ No Name of insurance company: | | | | |
| *Note: While I do not currently accept insurance, I am gathering information to determine which insurance I may take in the future.* | | | | |
| Have you had acupuncture before? ☐ Yes ☐ No If yes, please explain your experience: | | | | |
| How did you find out about *Jiv Daya Whole Health?* ☐ Friend ☐ Referred by_____ ☐ Location or drive/walk-by ☐ Yelp ☐ Website ☐ Facebook ☐ Other (please specify) _____ _____ | | | | |

**Main complaint/concerns(s)**: _____

_____

What diagnosis, if any, have you received? by whom? _____

How long has this been going on? _____ Do you know the root cause(s)? please explain briefly:

_____

_____

Are you undergoing treatment(s)? what type(s)? _____

What makes this problem worse? _____What makes this problem better? _____

To what extent does this problem interfere with your daily activities (sleep, work, relationships, exercise, mood, etc.)?

_____

Is there anybody in your family with similar complaints/concerns? _____

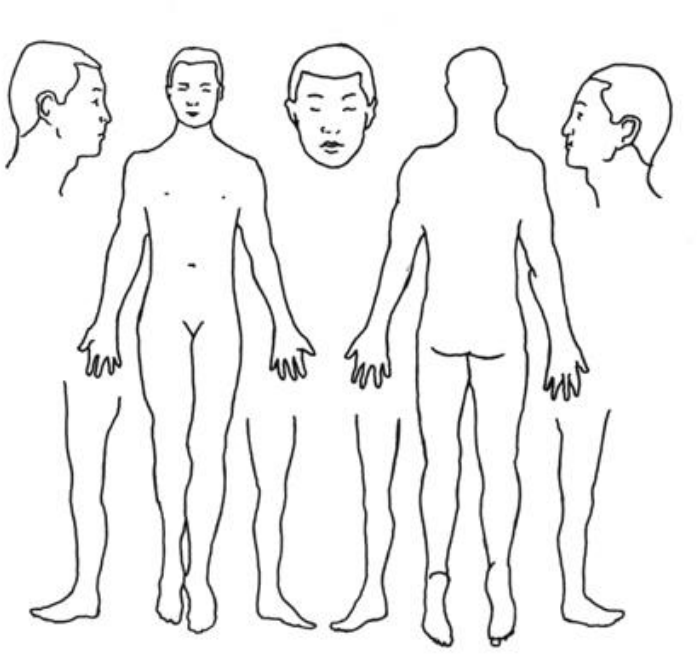
What do you hope to achieve from our visits together? What expectations do you have? What are your health goals?

_____

_____

_____

**Indicate painful or distressed areas (please circle):**



**On a scale of 0 to 10, what is your level of discomfort today? please circle:**

**(0 is no discomfort, 10 is the most discomfort)**

**0 1 2 3 4 5 6 7 8 9 10**

**Please describe the quality of the discomfort:**

- ☐ Sharp pain
- ☐ Dull pain
- ☐ Intermittent pain (goes away and comes back)
- ☐ Shooting pain (moves/travels to other areas)
- ☐ Numbness
- ☐ Tingling
- ☐ Other (please describe): _____

**Medical History**

| Diagnosis | Self | Family | Diagnosis | Self | Family | | Self | Family |
|---|---|---|---|---|---|---|---|---|
| Cancer | | | Breathing problems | | | Tuberculosis | | |
| Diabetes | | | Heart disease | | | High cholesterol | | |
| Hepatitis | | | Venereal disease | | | High blood pressure | | |
| Thyroid disease | | | Digestive disorders | | | Low blood pressure | | |
| Seizures | | | Alcoholism | | | Fainting | | |
| Arthritis | | | Depression or anxiety | | | Anemia | | |
| Other (please explain): | | | | | | | | |

**Previous Surgeries:** _____

**Previous Hospitalizations:** _____

**Significant traumas (physical or emotional):** _____

_____

**Allergies:** (drugs, chemicals, foods, environmental):_____

**Please list all current Medication:** (prescription drugs, over-the-counter drugs, vitamins, herbs, etc. and their dosages):

_____

_____

_____

**Habits:**

Do you smoke? □ Yes □ No What do you smoke? _____ How much per day? _____ For how long? _____

Do you use recreational drugs? □ Yes □ No If yes, please list: _____

Do you drink alcohol? □ Yes □ No What kind of alcoholic beverages? _____ # of drinks/week? _____

Do you drink coffee? □ Yes □ No □ Decaf How many cups of coffee per day? _____

Do you drink sodas? □ Yes □ No What type of soda? _____ How many sodas do you drink per day? _____

**Water Intake:**

How much water do you drink per day? _____ Do you prefer: □ ice water □ cold water/no ice □ room temp water

What other beverages do you drink regularly? _____

**Exercise:**

Do you exercise regularly? □ Yes □ No How many days per week? _____ For how long? _____

What type of exercise do you do? _____

**Sleep:**

Average hours of sleep per night: _____ What time do you go to bed? _____ What time do you wake up? _____

**Diet:**

Describe your current dietary lifestyle:

□ Carnivore (mostly meat) □ Omnivore (meat & veggies) □ Pescatarian (fish & veggies) □ Vegetarian □ Vegan

□ Gluten-free □ Dairy-free □ Sugar-free □ Low-Carb □ Paleo □ Other _____

Are you aware of foods that make you feel worse (foggy-headed, fatigued, bloated, upset stomach, reflux, etc.)

_____

Do you eat at regular times throughout the day? □ Yes □ No, explain: _____

Do you snack between meals? □ Yes □ No If you skip meals do you ever feel: □ lightheaded □ fatigued □ moody

Please describe your average daily diet (Please be as specific as possible):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

**Please check if you have or have had (in the last three months) any of the following diseases or conditions.**

**General:** □ Poor appetite □ Poor sleep □ Fatigue □ Fevers □ Chills
□ Night sweats □ Sweat easily □ Tremors □ Cravings □ Change in appetite
□ Poor balance □ Bleed or bruise easily □ Localized weakness □ Weight loss □ Weight gain
□ Peculiar tastes □ Desire hot food □ Desire cold food □ Strong thirst (cold or hot drinks)
□ Sudden energy drop (What time of day) _____
Favorite season of the year: □ Fall □ Winter □ Spring □ Summer
Least favorite season of the year: □ Fall □ Winter □ Spring □ Summer

**Skin & hair:** □ Rashes □ Ulcerations □ Hives □ Itching □ Eczema
□ Pimples □ Acne □ Dandruff □ Dry skin □ Recent moles □ Loss of hair
□ Purpura □ Change in hair or skin texture □ Other _____

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**Musculoskeletal:** □ Joint disorders □ Muscle weakness □ Pain/soreness in the muscles □ Tremors
□ Cold hands/feet □ Difficulty walking □ Swelling of hands/feet □ Spinal curvature □ Back pain □ Hernia
□ Numbness □ Tingling □ Paralysis □ Neck tightness □ Neck pain □ Shoulder pain
□ Hand/wrist pain □ Hip pain □ Knee pain □ Joint sprain □ Other _____

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**Head, eyes, ears, nose, & throat:** □ Dizziness □ Concussions □ Migraines □ Glasses/lens
□ Eye strain □ Eye pain □ Color blindness □ Night blindness □ Poor vision □ Cataracts
□ Blurry vision □ Earaches □ Ringing in ears □ Poor hearing □ Spots in front of eyes
□ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain □
Jaw clicks □ Sores on lips/tongue □ Difficulty swallowing □ Other _____

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**Cardiovascular:** □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting
□ Phlebitis □ Irregular heartbeat □ Rapid heartbeat □ Varicose veins □ Other _____

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**Respiratory:** □ Cough □ Coughing blood □ Wheezing □ Difficulty breathing
□ Bronchitis □ Pneumonia □ Chest pain □ Production of phlegm – What color? _____

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**Gastrointestinal:** □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas
□ Belching □ Black stools □ Blood in stools □ Indigestion □ Bad breath □ Rectal pain
□ Hemorrhoids □ Abdominal pain/cramps □ Gallbladder problems □ Parasites □ Chronic laxative use

**Bowel movements:**

□ firm □ loose □ diarrhea □ hard/constipation □ other, please describe _____

Frequency (how many times/day): _____ Color _____ Strong Odor? □ Yes □ No

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**Neuro-psychological:** □ Loss of balance □ Lack of coordination □ Concussion □ Other _____

□ Depression □ Anxiety □ Stress □ Bad temper □ Bi-polar

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**Genito-urinary:** □ Painful urination □ Frequent urination □ Blood in urine □ Urgency to urinate

□ Kidney stones □ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infection

□ Genital pain □ Genital itching □Genital rashes □ STD □ Other _____

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**Female:** □ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Vaginal/genital discharge

□ Fibroids □ Ovarian cysts □ Irregular periods □ Clots □ Pain/cramps prior/during periods

□ Breast tenderness □ Breast Lumps □ Fertility Problems □ Hot flashes □ Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? □ Yes □ No If yes, what type and for how long? _____

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**Male:** □ Prostate problems □ Discharge □ Erectile dysfunction □ Ejaculation problems

□ Frequent seminal emission □ Fertility problems □ Painful/swollen testicles □ Other

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**Are there any other health issues you want to discuss?**

I have completed this form correctly to the best of my knowledge.

**Signature:** _____ □ Adult Patient □ Parent or Guardian □ Spouse