Initial Patient Intake Form

Full Name_____
Date of Birth_____Age_____
Occupation_____
Main phone #_____Other phone #_____
E-mail _____Allow email contact by Tallgrass Yes No
Address: _____City _____State____ Zip_____
Relationship status _____ # of Children _____
Primary Care Physician_____ Chiropractor_____
Employer_____
Emergency Contact name_____ Phone _____
What pronouns do you prefer (e.g., he/ him, she/her)?_____

What is your current gender identity?
(Check and/or circle ALL that apply)
o Male
o Female
o Transgender Male/Trans Man/FTM
o Transgender Female/Trans Woman/MTF
o Genderqueer
o Additional category (please specify):
_____
o Decline to answer

What sex were you assigned at birth?
(Circle one)
Male
Female
Decline to Answer

Main
Problem(s):_____
_____
_____
_____

What was the Diagnosis, if any, have you received for this problem?_____

When did it begin? _____ What are the causes? _____

To what extent does this interfere with your daily activities (work, sleep, sex. Etc.)_____

What makes this problem Better?_____

What makes this problem Worse? _____

What kinds of treatments have you tried? _____

Is there a family history of this problem? _____

Additional Information: _____

Tallgrass Acupuncture and Wellness, LLC

List of Medications take in the last two months: (OTC and Prescribed, Dosage and Frequency)

_____

_____

Personal: Height_____ Weight_____ Weight one year ago_____

Weight Maximum_____@year_____

Habits: Do you smoke: Yes No How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly? Yes No Describe program_____

How many hours of sleep do you get in general?_____ What time do you go to bed?_____

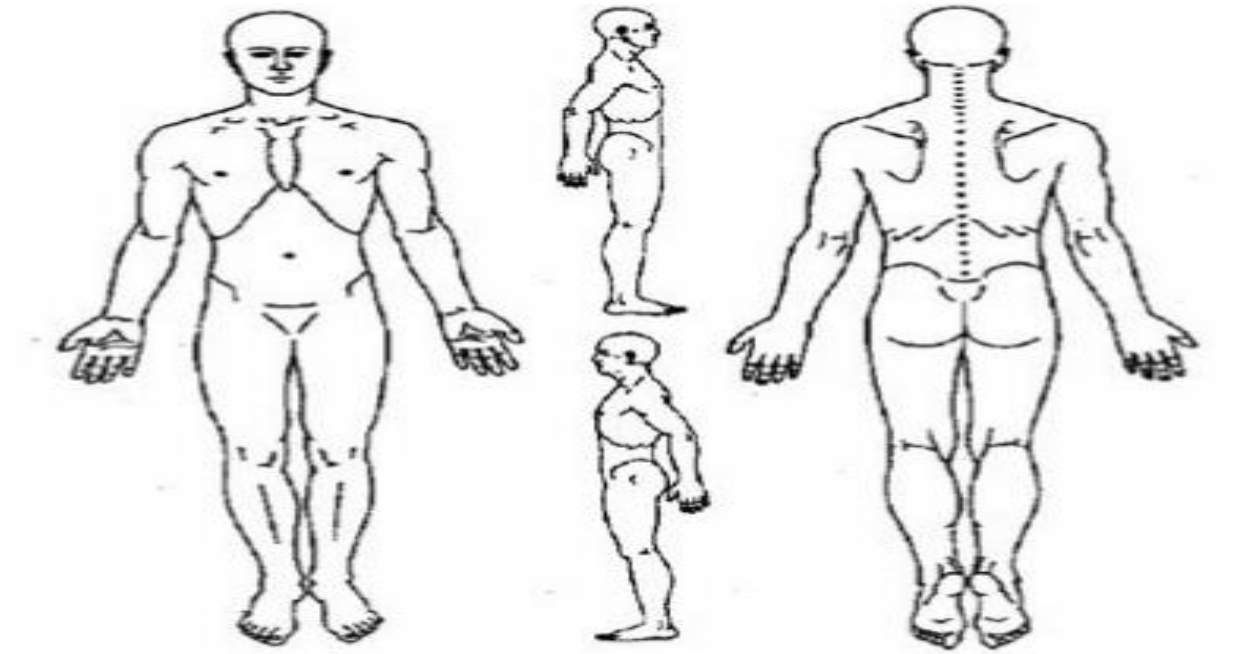
Diet: How much coffee do you drink? _____cups/day Sodas_____ /day Tea_____/day

What kind of alcoholic beverages do you usually drink, if any?_____ Average #/week: ____

How much water do you drink per day? _____cups

Are you a vegetarian? Yes No Yes, but not strict Do you eat a lot of spicy food? Yes No
Additional information on diet: _____

Please mark on the Diagram where you are experiencing: injury, pain, or discomfort



Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Breathing Problems			Tuberculosis		
Diabetes			Heart Disease			High Cholesterol		
Hepatitis			Digestive Disorder			High Blood Pressure		
Thyroid Disease			Venereal Disease			Emotional Disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or Anxiety			other		

Surgeries:(Type,Location,Date)_____
_____

Please circle if you have had any of the following diseases or conditions in the last 3 months.

General:

Poor Appetite	Tremors	Peculiar tastes
Poor Sleep	Cravings	Desire for hot food
Fatigue	Change in Appetite	Desire for cold food
Fever	Bleed or bruise easily	Strong thirst
Chills	Localized weakness	Sudden Energy drop time of day_____
Night Sweats	Weight loss	Favorite time of year_____
Easily sweaty	Weight gain	Worst time of year _____

Skin and Hair:

Pimples	Eczema	Loss of hair
Rashes	Acne	purpura
Ulcerations	Dandruff	Change in skin texture
Hives	Dry skin	Other: _____
Itching	Recent moles	

Musculoskeletal:

Joint disorders	Difficulty walking	Tingling
Muscle weakness	Swelling of hands/feet	Paralysis
Pain/soreness in muscles	Spinal curvature	Neck tightness
Tremors	Back Pain	Neck pain
Cold hands and feet	Hernia	Shoulder pain
Hand/wrist pain	Numbness	Hip Pain
Knee pain	Joint spasms	Joint sprain
Other_____		

Head, Eyes, Ears, Nose and Throat:

Dizziness	Night blindness	Grinding teeth
Concussion	Poor Vision	Teeth problems
Migraines	Cataracts	Facial pain
Glasses/ contacts	Blurry Vision	spots in front of eyes
Eye Strain	Earaches	poor hearing
Eye pain	Ringing in ears	Jaw clicks
Color blindness	Sore throat	sores on lips or tongue
Difficulty swallowing	Other_____	

Cardiovascular

High Blood Pressure	Phlebitis
Low blood pressure	Irregular heartbeat
Chest pain	Rapid heartbeat
Palpitations	Varicose veins
Fainting	Other_____

Respiratory:

Cough	Pneumonia
Coughing blood	Chest pain
Wheezing	Production of phlegm _____color?
Difficulty Breathing	Other_____
Bronchitis	

Gastrointestinal

Nausea	Blood in stool	Parasites
Vomiting	Indigestion	Chronic laxative use
Diarrhea	Bad breath	
Constipation	Rectal pain	
Gas	Hemorrhoids	
Belching	Abdominal pain/cramps	
Black Stool	Gallbladder problems	

Bowel movements: Frequency_____ Color_____ Odor_____ Texture/ Form_____

Neuro-psychological

Loss of balance	Anxiety
Lack of coordination	Stress
Concussion	Bad temper
Depression	Bi-polar
Other_____	

Tallgrass Acupuncture and Wellness, LLC

Urinary:

Painful urination	Unable to hold urine	Genital itching
Frequent urination	Dribbling	Genital rash
Blood in urine	Pause in flow	STD
Urgency to urinate	Frequent urinary tract infection	
Kidney stones	Genital pain	

Other_____

Reproductive:

Frequent vaginal infection	Breast lumps
Pelvic infection	Breast tenderness
Endometriosis	Clots in period
Vaginal/genital discharge	Fertility Problems
Fibroids	Hot flashes
Ovarian cysts	Moodiness related to period
Irregular periods	pain/cramps during period

____Number of pregnancies ____Number of Births ____Miscarriages ____Abortions

____Premature births ____C-sections _____Difficult deliveries

Last date of menstrual period_____

Are you currently, or could you be pregnant? Yes No

Age of first menstrual period_____ Average length of period _____days

Length of Cycle _____days Do you practice birth control? Yes No
what type and how long have you used it_____

Prostate problems	Fertility problems
Discharge	Painful/swollen testicles
Erectile dysfunction	Other_____
Ejaculation issues	
Frequent seminal emission	

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

Signature: Adult patient Parent or Guardian Spouse

Date: