DURANGO ACUPUNCTURE AND ALLERGY RELIEF

CALEB GATES, L.Ac

PATIENT INTAKE FORM

Date: _____

PATIENT INFORMATION			
Last Name:	First:	Middle:	Date of Birth:

Chief Complaint Currently: _____

Additional Health Priorities:

1._____ 3._____

2._____ 4._____

SYMPTOMS

Symptom & Description (worst first)	**Known triggers Worse (<) or better (>) for…**	**When Started**	**Rating: 1 → 10: 1 = hardly there 10 = extremely bad**

Amount/Level Of	Very Low	Low	Medium	Hight	Excessive	Erratic
General Energy						
Sleep						
General Appetite						
General Thirst						
Circulation/warmth/heat						
Daily Exercise						

Exercise Routine: _____

Energy is best: ☐ a.m. ☐p.m. ☐Night ☐Between meals ☐Just after meals ☐When moving ☐ Or still

Energy is worst:☐ a.m. ☐p.m. ☐Night ☐Between meals ☐Just after meals ☐When moving ☐ Or still

MIND & EMOTIONS: Tick if Current: ☐Mood Swings ☐Anger/Frustration ☐Grief/Sadness ☐Racing Mind
☐Worry ☐Fear ☐Brain Fog ☐Poor Memory ☐Poor Concentration ☐Difficulty Communicating

STRESS: Current stress level between 1 and 10 _____ (1 = very relaxed 10 = very stressed)

Factors most contributing to your stress: Health _____ Work _____ Money_____ Family_____ Other_____

What best helps you deal with stress? _____

SYSTEMS CHECK: **Check** any current problems.

General Symptoms

☐ Sweat Easily
☐ Cold Limbs
☐ Recent Weight Loss
☐ Poor Sleeper
☐ Fatigue
☐ Prefer Cold Drinks
☐ Weak Immunities
☐ Hot Flashes
☐ Cold Body
☐ Overweight
☐ Normal Energy Level
☐ Prefer Warm Drinks
☐ High Metabolism
☐ Night Sweat
☐ Feel Warm Mostly
☐ Underweight
☐ Feel Thirsty Often
☐ Strong Immunities
☐ Low Metabolism
☐ Lack of Thirst

When I am active I sweat: ☐a lot ☐little ☐almost never

I usually sweat on

☐my head
☐face
☐neck
☐back
☐upper body
☐arm pit
☐lower body
☐whole body
☐palm and sole

Sleep

☐ Problem getting to Sleep
☐ Frequent Waking
☐ Early Waking
☐ Wake Unrefreshed
☐ Sleepiness
☐ Night Sweats
☐ Grinding Teeth
☐ Dreams
☐ Nightmares
☐ Snoring
☐ Early Waking
☐ Fall Asleep without Meds or Supplements

_____ Hours slept per night
_____ Typical Bedtime
_____ Typical Wake time

Infections

☐ Recurring Frequent Colds
☐ Flu
☐ Sinusitis
☐ Chest
☐ Ear
☐ Bladder
☐ Cystitis
☐ Kidney
☐ Stomach
☐ Food Poisoning
☐ Poor Immunity
☐ General 'run down'
☐ Intestinal
☐ Swollen Lymph Nodes
☐ Phlegm
☐ Fevers

Head

☐ Headaches
☐ Migraines
☐ Seizures
☐ Panic Attacks
☐ Poor Hearing
☐ Ringing
☐ Blurred Vision- Distance
☐ Blurred Vision- Near
☐ Visual Spots
☐ Confusion
☐ Anxiety
☐ Loss of Consciousness
☐ Bi-Polar Disorder
☐ Mental Disorders
☐ Nervousness
☐ Dizziness/Vertigo
☐ Depression
☐ Presently in Counseling
☐ Considered/Attempted Suicide
☐ ADD/ADHD

Cardiovascular

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Low Blood Pressure
- ☐ Low Cholesterol
- ☐ Irregular Heart Beat
- ☐ Bruise Easily
- ☐ Chest Pain/ Pressure
- ☐ Heart Attack
- ☐ Cardiovascular Disease
- ☐ Stroke
- ☐ Anemia
- ☐ Edema - (Legs/Hands/Eyes)

Respiratory

- ☐ Coughing
- ☐ History Sinus Infections
- ☐ Phlegm
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Tight Chest
- ☐ Allergies
- ☐ History Pneumonia
- ☐ Post Nasal Drip
- ☐ Bronchitis/Emphysema
- ☐ Sinus Congestion
- ☐ Nose Bleeds

Urination

- ☐ Frequent Urination
- ☐ Bladder/Kidney Stones
- ☐ Urgency to Urinate
- ☐ Urinary Incontinence
- ☐ Blood in Urine
- ☐ Difficult Urination
- ☐ Painful Urination
- ☐ Recurrent Urinary Infections
- ☐ Kidney Disease
- ☐ Cloudy/Bubbly Urine

_____ # of glasses a water a day Is your urine clear? (If no, please describe) _____

_____# of times night urination Do you have any urinary diseases diagnosed by an MD? _____

Gastrointestinal

- ☐ Bowel Habits Changed
- ☐ Bloating
- ☐ History of Candida
- ☐ Laxative Use
- ☐ Gallbladder Troubles
- ☐ Nausea
- ☐ Heartburn
- ☐ Gas
- ☐ Constipation
- ☐ Ulcers
- ☐ Blood in Stool
- ☐ History of Parasites
- ☐ Mouth Tastes Bitter/Sour
- ☐ Vomiting
- ☐ Acid Reflux
- ☐ History of Polyps
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Hemorrhoids
- ☐ Diabetes
- ☐ Bad Breath
- ☐ Stomachaches
- ☐ Belching
- ☐ Rectal Itching
- ☐ Chronic Loose Stools
- ☐ Dry Hard Stools

Do you have any digestive diseases diagnosed by an MD? _____

Bowel Movements every _____days(s) # per day_____

When passing the bowel does it most of the time ☐feel complete or ☐uncomplete?

When passing the bowel do you ☐sit for a prolonged period ☐need to push or ☐is it excreted in a few seconds? *Stools Tend to be:* ☐ Well Formed ☐ Loose (L) ☐ Constipated (C) ☐ Alternating (L & C)

Skin & Hair

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Itchiness
- ☐ Dryness
- ☐ Spots
- ☐ Athlete's Foot
- ☐ Jock Itch
- ☐ Hair Loss
- ☐ Dermatitis/Warts
- ☐ Brittle Hair
- ☐ Skin Rashes
- ☐ Early Gray
- ☐ Dry Scalp
- ☐ Facial Hair
- ☐ Acne
- ☐ Hives
- ☐ Fungal Infections
- ☐ Had Shingles

Do you have any skin diseases diagnosed by an MD?_____

Musculoskeletal

- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Sensitivity
- ☐ Poor Mobility
- ☐ Poor Coordination
- ☐ Muscle Weakness
- ☐ Pain Back
- ☐ Pain Neck
- ☐ Pain Shoulder
- ☐ Swollen Joints
- ☐ Tendonitis
- ☐ Bone Pain
- ☐ TMJ
- ☐ Muscle Pain
- ☐ Repetitive Strain Injury
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Muscle Spasms/Cramps
- ☐ Recurring Pain _____

Mark any muscular soreness and/or pain on the picture model using the following symbols:

+++ = Sharp Stabbing

ooo = Pins & Needles/Tingling

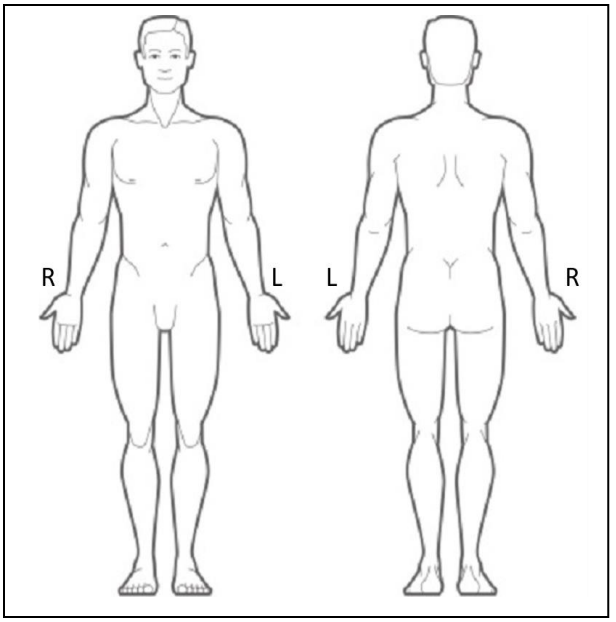
vvv = Dull or Aching

lll – Numbness

--- = Trembling or Twitching

Severity of pain on a scale of 1 to 10 (1 is low) _____

Is the pain fixed or does it move? _____



Sensory

- ☐ Eye Irritation
- ☐ Color Blindness
- ☐ Ear Congestions
- ☐ Loss of Smell
- ☐ Mouth Sores
- ☐ Spots in Vision
- ☐ Poor Hearing
- ☐ Gum/Teeth Problems
- ☐ Night Blindness
- ☐ Ear Ringing
- ☐ Nasal Discharge
- ☐ Dry Mouth & Throat
- ☐ Lumps in Throat
- ☐ Tearing Eyes

Do you have any sensory diseases diagnosed by an MD?_____

Note: If you feel ready to be open in this area, the purpose of the following is to enable us to better assist your health.

<u>Men Only</u>:

- ☐ Sexual Impotence
- ☐ Low Libido
- ☐ Genital Discharge
- ☐ Swelling
- ☐ Testicular Pain
- ☐ Infertility
- ☐ Prostate Problems
- ☐ Hepatitis (A, B, or C)
- ☐ Hernias
- ☐ Herpes
- ☐ Increased Sex Drive
- ☐ HIV Positive
- ☐ Decreased Sex Drive

<u>Women Only</u>: # of Children _____ # of Miscarriages _____ # of Abortions _____

Menses: ☐Late ☐Early ☐Regular ☐ Irregular ☐Absent Days of Period _____ Time Between Periods_____

The flow has been: ☐Heavy ☐Light ☐Regular ☐Dark Menses ☐PMS ☐Clotty menses ☐Cramps

Birth Control Type: _____ Dates on Birth Control Pill _____

List any symptoms which are worse ☐Before ☐During menses: _____

- ☐ Infertility/Fertility Issues
- ☐ Pregnant now
- ☐ Planning pregnancy
- ☐ Herpes
- ☐ Increased Sex Drive
- ☐ Yeast Infection
- ☐ HIV Positive
- ☐ Decreased Sex Drive
- ☐ Vaginal Discharge
- ☐ Hepatitis (A, B, or C)
- ☐ Hot Flashes/Night Sweats
- ☐ Mood Swings
- ☐ Breast Tenderness
- ☐ History of Fibroids/Cysts
- ☐ Low Libido
- ☐ Difficult birth(s) Details: _____

DIET

How much do you eat/drink of the following:	None	Very Little	Moderate	Very Much
Vegetables	____	____	____	____
Beans/legumes, nuts, seeds	____	____	____	____
Meat, fish (Which? _____)	____	____	____	____
Chicken, turkey, or eggs (not organic, even if free range)	____	____	____	____
Chicken, turkey, or eggs (organic)	____	____	____	____
Dairy Foods: milk, cheese, yogurt, etc.	____	____	____	____
White flour/starches: bread, pasta, potatoes, rice	____	____	____	____
Whole grains: whole wheat, oats, spelt, barley, rye	____	____	____	____
Sweets: cakes, biscuits, puddings, chocolate, soft drinks…)	____	____	____	____
Fruit and/or Fruit Juice	____	____	____	____

Amount of water consumed daily (on its own): _____ Mark the type(s) of water you drink:

☐Tap ☐Filtered Tap ☐Reverse Osmosis ☐Distilled ☐Bottled What Brand? _____

Your known Allergies/ Sensitivities ☐Many ☐Few ☐Don't Know _____

_____

MEDICAL HISTORY / PAST TREATMENTS

☐ Tuberculosis
☐ Scarlet Fever
☐ Rheumatic Fever
☐ Venereal Disease
☐ Epilepsy/Seizure Disorder
☐ Mental Illness/Depression
☐ Auto-Immune
☐ Fibromyalgia
☐ Hepatitis A/B/C
☐ Osteoporosis
☐ Pacemaker
☐ Substance Abuse
☐ Mononucleosis
☐ Cancer
☐ Chronic Fatigue
☐ Thyroid
☐ Diabetes

Have you ever had a negative reaction to any medications? ☐Yes ☐No

If so, which medication and what was the reaction? _____

Approximate number of course of **Antibiotics** received in your life: ☐0-10 ☐11-20 ☐21+

For what? _____When was last one received? _____

Approx. number of **X-rays** received in your life: ☐0-10 ☐11-20 ☐21+ When was last one received? _____

For what? (mammograms, injuries, dental, chest, etc)_____

Vaccination

Approximate number of **Vaccinations** received in your life: ☐0-10 ☐11-20 ☐21+

Which ones? _____ When was last one received? _____

Have you received any Flu Vaccinations any time in your life? ☐ Yes ☐ No When?_____

Have you ever had negative reactions to any vaccinations? ☐ Yes ☐ No Explain:_____

_____

DENTAL HISTORY

Current number of dental amalgam fillings (these are silver or black colored): _____ Tooth Pain _____

How long since the first one was placed? _____ Total number that have been removed: _____

When removed? _____ Removed by ☐ Regular dentist or ☐ Holistic mercury-free dentist

Did your mother have amalgam fillings before your birth? ☐Yes ☐ No ☐Probably ☐No idea

Did your father and/or grandparents have amalgam fillings? ☐Yes ☐ No ☐Probably ☐No idea

Number of gold caps, root canals or other dental restorations (please indicate):_____

Medications

Briefly list your previous treatment / detoxification history (including conventional or alternative medicine):

WHEN BEGUN	WHEN ENDED	TREATMENT	WHEN BEGUN	WHEN ENDED	TREATMENT

ACCIDENTS / HOSPITALIZATIONS / SURGERIES

Have you ever been knocked unconscious? _____ Any blows to the ☐head ☐spine ☐other injuries?

Details: _____

INCIDENT	DATE	INCIDENT	DATE

CURRENT TREATMENTS

List medications you currently use (prescribed or over-the-counter): **BRING A SAMPLE OF EACH TO YOUR APPT.**

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

☐Long Term Medications(s) ☐Past ☐Present Details: _____

Any negative reactions to medication? _____

Have you had Bloodwork / X-rays / CT Scans or any other studies pertaining to your current condition(s) **done within the past year**? ☐Yes ☐ No Results:_____

List supplements / homeopathies / herbs you currently taking: **BRING SAMPLES OF THESE TOO!**

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

Is any other practitioner providing treatments/therapies for you at the present time? ☐Yes ☐No

Details: _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings
HEART DISEASE					
HIGH BLOOD PRESSURE					
STROKE					
TUBERCULOSIS					
CANCER					
GLAUCOMA					
DIABETES					
EPILEPSY					
BLEEDING DISORDER					
KIDNEY DISEASE					
THYROID DISEASE					
MENTAL ILLNESS					

TOXICITY

Do you smoke? ☐ Yes ☐ No Have you ever smoked ☐ Yes ☐ No Smokeless Tobacco ☐ Yes ☐ No

Packs/Cans daily_____ How long? _____ When stopped? _____

Have you used recreational drugs? ☐ Yes ☐ No

Please note any that apply to you now or in the past, and indicated your usage per day or week.

	Per Day/Week	Age Started	Age Quit	History of Addiction	Family History of Addiction
Tobacco					
Alcohol					
Coffee					
Marijuana					
Cocaine					
Heroine					
Other					

Cups (8oz) of caffeinated beverages a day: _____

Average alcohol consumption per week: _____ ☐ History of alcohol addiction

Have you ever been exposed to industrial/chemical toxins at work or home? (e.g. factory, farming…) ☐ Yes ☐ No

What chemicals/what industry/how long?_____ When stopped? _____

Have you ever used weed killer or other agricultural chemicals? ☐Yes ☐No

Do your neighbors? ☐ Yes ☐ No ☐ No Idea

Do you use a coal stove/fire (either regular or 'smokeless' coal)? ☐ Yes ☐ No

Do your neighbors? ☐ Yes ☐ No ☐ No Idea

Do you live near any of the following (i.e. within 1 – 2 miles, OR further if downwind)

☐ Nuclear Plant ☐ Crematorium ☐ Industrial Zone ☐ Polluting Factory ☐ Golf Course
☐ Agricultural Area

Have you ever been exposed to any other known major environmental toxins? ☐ Yes ☐ No ☐ No Idea

Please explain: _____

EMFS

Your home is a ☐ House ☐Apartment Which apartment floor? _____ How many stories? _____

How far is the nearest: Mobile phone mast _____ Electricity pylon _____ High power generator _____

Describe the view from your bedroom window: _____

Do you use: ☐ Cordless phone ☐Wifi ☐Electric: blanket, shaver, toothbrush ☐Protective devices ☐Magnets

Number of ____Fluorescent lights _____ Striplights _____ Long life (mercury) lightbulbs in your Home Office

Do any direct neighbors have a cordless phone? ☐Yes ☐No ☐No idea

Number in your home: TVs _____ Computers/Laptops _____

Check specifications of each: How many are "LCD"? _____ vs. "LCD/LED"? _____

If unsure, write here all TV and Computer brand names: _____

_____

Do you use a laptop **without** an external keyboard and mouse? ☐Yes ☐No

Do you use any phones: ☐Held to ear ☐Speakerphone function

Type of heating used in home: _____ Which room do power lines enter? _____

	Average Hours of Use per **Day**
TV	
Computer or Tablet	
Mobile phone	
Landline phone	
In a motor vehicle	

Devices in your bedroom: ☐TV ☐Computer ☐Clock radio ☐Lamp ☐Mobile phone ☐Other appliances

TRAVEL

Have you ever travelled to remote regions (e.g. Asia, Africa, South America) ☐ Yes ☐ No

Date	Destination	Health Incidents There or After?	Date	Destination	Health Incidents There or After?