The Gate to Wellness LLC
Armeta Dastyar M.O.M., L.Ac.

Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential

Name: _____ _____ Gender: ___ Male ___ Female
(Last Name) (First Name)

Date of Birth: ____/_____/_____ Age:_____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Phone: Home: _____ Cell: _____ (Please circle preferred contact number- Home or Cell)

Single: _____ Married: _____ Seperated/Divorced: _____ Widowed: _____ Partnered: _____

Occupation: _____

Emergency Contact: _____ _____ Relation: _____
(Last Name) (First Name)

Emergency Contact Telephone: Home: _____ Cell: _____

Name of Physician: _____ Phone number: _____
*(no contact will be made without your permission)

Have you ever been treated with acupuncture before? (circle one) Yes No

How did you hear about me? _____

Goals- *what health concerns would you like to address through treatment?*

_____
_____
_____

Do you have any infectious disease that you know of? Yes No

If Yes, please list: _____

Is there any chance you're pregnant: Yes No

Please list any known allergies or food sensitivities:

_____
_____

Medical: Please provide date and reason for any past surgeries and/or hospitalizations:

Year	Operation/Illness	Hospital

Please list all medicines, vitamins, and/or food supplements you are currently taking:

Medications & supplements	Dosage	For what Condition?

Lifestyle Habits:

Alcohol (drinks per week) _____ Types? _____

Coffee/Tea (cups per day) _____ Soda (cups per day) (regular or diet) _____

Cigarettes (packs per day) _____

Recreational Drugs: _____ What types and how often? _____

Exercise (times per week)_____ What type and how often? _____

How much water do you drink a day? _____

Please put a "C" if the condition is current or a "P" if you had it in the past

General
__ Insomnia
__ Dreams/ nightmares
__ Fatigue
__ Wake un-refreshed
__ Poor memory
__ Low energy
__ General Weakness

Temperature
__ Cold hands and feet
__ Hot overall
__ Cold overall
__ Night sweats
__ Hot flashes
__ Thirsty
__ Perspire easily
__ Lack of perspiration
__ Chills
__ Fever

Head & Neck
__ Headaches
__ Migraines
__ Stiff neck
__ Dizziness
__ Fainting
__ Swollen glands

Ears
__ Ringing
__ Hearing loss
__ Hearing aids
__ Infections
__ Earache
__ Vertigo

Eyes
__ Glasses/ contact lenses
__ Blurred vision
__ Poor night vision
__ Spots or floaters
__ Eye inflammation
__ Double vision
__ Glaucoma
__ Cataracts
__ Itchy
__ Dry
__ Watery

Nose, Throat & Mouth
__ Sinus infection
__ Hay fever/ allergies
__ Frequent sore throat
__ Difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent colds
__ Nosebleed
__ Dry nose
__ Nasal congestion
__ Loss of voice
__ Thirst
__ Excessive phlegm
__ TMJ
__ Facial pain
__ Gum problems
__ Dry mouth

Skin
__ Hives
__ Rashes
__ Eczema/ psoriasis
__ Dry skin
__ Easily bruised
__ Changes in moles
__ Lumps
__ Itching

Respiratory
__ Difficulty breathing
__ Wheezing
__ Asthma
__ Chronic cough
__ Wet cough
__ Dry cough
__ Coughing up phlegm
__ Coughing up blood
__ Shortness of breath
__ Tight chest
__ Pneumonia

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitations
__ Rapid heart beat
__ Irregular heart beat
__ Poor circulation
__ Swollen ankles
__ Anemia
__ History of heart attack

Gastrointestinal
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Loose Stool
__ Constipation
__ Bloody stool
__ Undigested food in stool
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid regurgitation
__ Bloating
__ Prolapsed organs (diagnosed): _____
__ Recent weight loss/gain

Musculoskeletal
__ Joint pain/disorder
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Neck/shoulder pain
__ Upper back pain
__ Lower back pain
__ Rib pain
__ Limited range of motion
__ Swollen hands or feet
__ Swollen joints
__ Lump in throat
__ Other (describe)
_____

Neurological
__ Seizures
__ Tremors
__ Numbness or tingling
__ Pain (describe)
_____
__ Paralysis
__ Poor coordination
__ Other (describe)
_____

Mental/Emotional
__ Depression
__ Mood swings
__ Anger easily
__ Frustration
__ Irritability
__ Difficulty relaxing
__ Loneliness
__ Sensitive
__ Shy
__ Cry often
__ Worry a lot
__ Compulsive behaviors
__ Difficulty focusing
__ Hopeless outlook
__ Suicidal thoughts
__ Lose temper
__ Frustration
__ Mental fogginess

Urinary
__ Pain on urination
__ Frequent urination
__ Urgent urination
__ Blood in urine
__ Unable to hold urine
__ Incomplete urination
__ Bedwetting
__ Wake to urinate
__ Kidney stones

Male Genital
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain/itching of genitalia
__ Increased libido
__ Decreased libido
__ Lumps in testicles
__ Sexually transmitted disease(s) specify: _____

Gynecology (Women Only)
__ Currently pregnant: trimester _____
__ # of Pregnancies
__ # of Miscarriages
__ # of Abortions
__ Menopause
__ Hormone replacement therapy
__ Irregular periods
__ Menstrual cramps
__ Excessive blood flow
__ Menstrual blood clots
__ Breast tenderness
__ Abnormal pap smear
__ Vaginal infections
__ Vaginal pain/itching
__ Uterine fibroids
__ Endometriosis
__ Breast lumps, cysts
__ Increased libido
__ Decreased libido
__ Sexually transmitted disease(s) specify: _____

_____ _____
Client Signature Date