

Focus Physical Therapy & Wellness Center

193 Bellevue Avenue
Upper Montclair, NJ 07043

INTAKE FORM

Date: ____/____/____ Patient Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____

Telephone of a friend or relative you would want contacted in case of an emergency:

Name: _____ Number: _____

Sex: M: _____ F: _____ Height: _____ Weight: _____

Physician Name: _____ Physician Telephone: _____

Marital Status: M S W D – Do you currently have a partner (optional)?

Occupation: _____

Physician Diagnosis: _____

Allergies: _____

1. Have you ever had acupuncture before? Yes: ____ No: ____
Have you eaten today? Yes: ____ No: ____ At what time was your last meal? _____

2. Problem that brought you here today: _____

3. Has there been anything that has ever been able to change your problem in any way?

Yes: ____ No: ____ Please describe: _____

4. When did this problem first appear?: _____

5. Is it constant or does it come and go?: _____

6. If applicable, does the problem ever move? (for example, pain or spasms that occur in different joints or muscles at different times) Yes: _____ No: _____

7. If applicable, is the pain sharp or dull? _____

8. What makes your pain better? Please circle: heat or cold, movement or rest, pressure, massage. Describe any other ways in which your pain is made better.

9. Is your illness affected by seasonal changes? Please describe. _____

10. Other problems you would like addressed: _____

11. Are you currently on any medications? Please list. _____

12. Do you take any vitamins/supplements? Please list. _____

13. Have you had any surgeries? Yes:_____ No:_____ If yes, what kind of surgery, and when did you have it done? _____

14. History of Significant Illnesses (include all past accidents, childhood illnesses, and the dates that they occurred):

Self

Mother

Father

Grandparents

Grandparents

15. Do you smoke? Yes: ____ No: ____ If yes, the number of cigarettes you smoke per day: _____ or number of packs: _____

16. Do you drink alcohol? Yes: ____ No: ____ How many glasses per day: _____ per week: _____ per month: _____

17. Describe your sleep habits (for example, number of hours per night that you sleep do you have trouble falling asleep, or do you awake very early and are then unable to go back to sleep): _____

18. Describe your bowel habits: Regular Constipation Diarrhea

19. If you suffer from constipation, do you feel better or worse immediately after moving your bowels? _____

How many days pass before you move your bowels? _____

20. If you suffer from diarrhea, does it occur early in the morning when you first wake up? Yes: ____ No: ____ Does your rectum burn as the stool exits? Yes: ____ No: ____ How many episodes of diarrhea do you have per day? _____

21. Do you regularly experience abdominal pain? Yes: _____ No: _____
If yes, what makes it feel better? Please circle. Heat/cold Eating/Not eating
Massage Rest/movement Other: _____

22. Do you have any emotional difficulties? Please circle.
Anxiety Panic Attacks Depression Mania
Mood swings SAD

23. How would you rate your ability to concentrate/maintain focused thinking, and have clarity of thought? Please circle.
Poor Fair Good Excellent

24. Is your urine clear: scanty/abundant or dark: scanty/ abundant? Please circle.
How many times a day do you urinate?

25. How would you rate your appetite? Please circle.
Poor Moderate/Good Excessive

26. Do you crave sweets? Yes: _____ No: _____ List any other foods that you crave.

27. Do you get headaches often? Yes: _____ No: _____ If yes, is the headache always in the same location? Yes: _____ No: _____ Where?: _____

28. Do you ever experience dizziness? Yes: _____ No: _____

29. Are you often thirsty? Yes: _____ No: _____

30. Do you prefer cold or warm drinks? Please circle.

31. Do you often feel cold? Yes: _____ No: _____ If yes, where? Please circle:
Hands/feet Limbs Entire body Other: _____

32. Describe the degree to which you sweat: very little average excessive
On a moderate temperature day, do you tend to sweat more during the day or night?

33. Do you exercise? Yes: _____ No: _____ How often?: _____
What do you do?: _____

34. How would you rate your energy level?

Poor Fair Good Excellent Other: _____

35. Describe your diet: Number of vegetables eaten daily: _____

Number of meat products eaten daily: _____ Number of dairy products eaten

daily: _____ Number of caffeine containing products eaten

daily: _____ Number of whole grain products eaten daily: _____

36. Have you had any lymph nodes removed? Yes: _____ No: _____ If yes, please describe

37. Do you have any infectious diseases? Yes: _____ No: _____

38. Do you have a history of drug abuse? Yes: _____ No: _____

WOMEN ONLY

39. Is there any chance you could be pregnant? Yes: _____ No: _____

40. Are your menstrual cycles regular, irregular, early, or late? Please circle.

41. Is your menstrual flow normal, light, or heavy? Please circle.

42. Is the blood normal, purplish, dark, or light in color? Please circle.

43. Does your menstrual blood contain clots? Yes: _____ No: _____

44. Is your vaginal discharge clear/white and thin or yellow and thick? Please circle.

45. Do you have itching or soreness of the vagina? Yes: _____ No: _____

46. If you generally experience mood swings, use the choices below to describe how they are around the time of your menses.

Better Worse Same Not Applicable

47. Number of children: _____ Number of miscarriages: _____

Number of abortions: _____

Patient Signature

Physician Signature