GOLDEN PHOENIX ACUPUNCTURE & WELLNESS

6161 Dr MLK Jr St N, Suite 100, St. Petersburg, FL 33703

Extended Intake Form

Lifestyle:

⬜Alcohol # per day:_____ ⬜Stress ⬜Tobacco # per day:_____ ⬜Drugs

⬜Regular Exercise, Type:_____Frequency:_____

⬜Meditation, Frequency:_____

⬜Occupational Hazards:_____

⬜Dietary Restrictions (vegan, kosher, shellfish allergy):_____

Your Health History (Check any of the following conditions you currently have or have had in the past):

⬜ Adverse reaction to medical treatment
⬜ Alcoholism
⬜ Appendicitis
⬜ Arteriosclerosis
⬜ Arthritis or rheumatism
⬜ Attempted suicide
⬜ Birth trauma (your own birth)
⬜ Bleeding disorder
⬜ Cancer or tumor
⬜ Chicken pox
⬜ Diabetes
⬜ Eating disorder
⬜ Emphysema
⬜ Goiter
⬜ Gout
⬜ Heart disease
⬜ Hepatitis/liver disease
⬜ Herpes
⬜ HIV/AIDS
⬜ Immune disorder
⬜ Joint replacement
⬜ Kidney disorder
⬜ Lyme disease
⬜ Lymph nodes removed
⬜ Measles
⬜ Mental disorder
⬜ Multiple sclerosis
⬜ Mumps
⬜ Pacemaker
⬜ Polio
⬜ Rheumatic fever
⬜ Sciatica
⬜ Scoliosis
⬜ Scarlet fever
⬜ Seizures/epilepsy
⬜ Sinus infection
⬜ Skin disease
⬜ Stroke
⬜ Substance abuse
⬜ Thyroid disorders
⬜ Tuberculosis
⬜ Ulcers
⬜ Venereal disease/STD
⬜ Whooping cough
⬜ Other
_____
_____

Musculoskeletal (Please check all that apply):

⬜ Neck/Shoulder Pain
⬜ Muscle Pain
⬜ Upper Back Pain
⬜ Low Back Pain
⬜ Joint Pain
⬜ Rib Pain
⬜ Limited Range of Motion
⬜ Muscle Spasm
⬜ Other_____

Men Only:

⬜Testicle pain ⬜Penis pain ⬜Penis sores ⬜Discharge ⬜Premature ejaculation ⬜Nocturnal emission
⬜Impotence ⬜Other:_____

Women Only (Gynecology):

Are you pregnant? ⚪Yes ⚪No

Trying to get pregnant? ⚪Yes ⚪No

Age at menarche_____

Age at menopause_____

Length of cycle (day 1 to day 1):_____

Duration of flow:_____

Date last period began:_____

# of Pregnancies_____

# of Live Births_____

Abortions_____

⚪ Irregular periods

⚪ Painful periods

⚪ PMS

⚪ Clots

⚪ Vaginal odor

⚪ Vaginal sores

Medications, Herbs, Supplements (List those you are currently taking)**:**

Name_____Reason_____How long_____

Name_____Reason_____How long_____

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Name_____Reason_____How long_____

Name_____Reason_____How long_____

Name_____Reason_____How long_____

Name_____Reason_____How long_____

Family Health History (List any significant family physical or mental illnesses)**:**

_____

_____

Surgeries (type/year):

_____

_____

Traumatic Experiences (incident/year) - please indicate approximate dates and *briefly* describe the nature of any you have had (e.g. divorce, injury, family death, bankruptcy, etc.):

_____

_____

Under 18 - Responsible Party Information

Name:_____ Relationship to Patient:_____

I agree that the information on this intake is true. It is my responsibility to inform the Practitioners with Golden Phoenix Acupuncture at any point of my course of treatments if any information has changed.

Signature of Patient:_____ Date:_____