Arizona Natural Medicine Physicians, P.L.L.C.

We Listen. We Care. We Change Lives. TM

Kiera Lane, N.M.D., L.Ac., Dipl. Ac., FABORM | Darin Zimmerman, L.Ac.
2480 W. Ray Road, Suite 1 • Chandler, AZ 85224 •P (480) 722-2811 •F (480) 722-2817
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Date _____

Facial Acupuncture New Patient Intake Form

Legal Name _____/_____/_____
Last Name First Name middle initial

Preferred Name _____ **Age** _____ **Date of Birth (dob)** _____ **Sex** ☐ F ☐ M

Address _____

City _____ **State** _____ **Zip** _____

Email Address _____ **Sign Me Up For Free Monthly Newsletter ( ) Yes ( ) No**

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Occupation _____ ☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Student**

Employer's Name & Address _____

Driver's License # _____ **Issuing State** _____

Social Security # _____ **Education** _____

Emergency Contact _____ **Relationship** _____

Address _____ **Phone** (H)_____(W)_____(M) _____

Insurance Company _____ **Policy #** _____

Insurance Address _____

Name of Person Insured _____

Primary Care Provider (PCP) _____ **Last Time Seen By PCP** _____

Address _____ **Phone** _____

Referred By _____

Social History

Occupation _____ Years of Education? _____

Current Employment Status? ☐ Retired ☐ Unemployed ☐ Homemaker ☐ Employed

Past Occupation (s)? _____

Are you Disabled? ☐Yes ☐No Reason? _____

History of Physical, Emotional or Sexual Abuse? ☐Yes ☐No

Marital Status? ☐Single ☐Married ☐Divorced ☐ Separated ☐ In Significant Relationship (unmarried) ☐ Widow

Primary interests, hobbies, or activities: _____

_____

Habits

Do you get regular exercise? ☐Yes ☐No What form/How often? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much, how often, and what kind? _____

_____

Do you use other recreational drugs? ☐Yes ☐No If so, what kind and how often? _____

Do you use tobacco? If so, what kind, how much, and for how long have you used it? _____

Do you drink coffee? ☐Yes ☐No If yes, how much and how often? _____

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STRESS

Level of Stress? ☐ Low ☐ Moderate ☐ High Source of Stress? ☐ Work ☐ Financial ☐ Family/Relationship ☐ Other

PAST MEDICAL HISTORY (YOU)

Please check all that apply regarding **Your** personal health history (Family History is in another section)

Current	Past		Current	Past		Current	Past	
☐	☐	Anxiety	☐	☐	Crohn's Disease	☐	☐	Kidney Stones
☐	☐	Alcoholism	☐	☐	Depression	☐	☐	Liver Disorders
☐	☐	Allergies (Hayfever)	☐	☐	Diabetes	☐	☐	Multiple Sclerosis
☐	☐	Anemia	☐	☐	Diverticulosis	☐	☐	Neuropathy
☐	☐	Arthritis	☐	☐	Gastroesophageal Reflux (GERD)	☐	☐	Osteoporosis/Osteopenia
☐	☐	Autoimmune Disorder	☐	☐	Gallbladder Disease	☐	☐	PMS
☐	☐	Blood Clot (Leg)	☐	☐	Gout	☐	☐	Seizures
☐	☐	Blood Clot (Lung)	☐	☐	Headaches (General)	☐	☐	Skin Disorders
☐	☐	Blood Transfusion	☐	☐	Headaches (Migraines)	☐	☐	Sleep Apnea
☐	☐	Breast Lump (Benign)	☐	☐	Heart Disorders	☐	☐	Stroke
☐	☐	Cancer Breast	☐	☐	Herpes Genitalis	☐	☐	Thyroid (Hashimoto's)
☐	☐	Cancer Colon	☐	☐	High Blood pressure	☐	☐	Thyroid Disorders (Hypo)
☐	☐	Cancer Ovarian	☐	☐	High Cholesterol	☐	☐	Thyroid Disorder (Hyper)
☐	☐	Cancer Prostate	☐	☐	Hypoglycemia	☐	☐	Tuberculosis
☐	☐	Cancer	☐	☐	Injury (Serious)	☐	☐	Ulcerative Colitis (UC)
Other _____								
☐	☐	Colitis	☐	☐	Irritable Bowel Syndrome (IBS)	☐	☐	Venereal Disease

Other _____

FAMILY HISTORY

Check Yes or No for Blood Relatives Only (Mother, Father, Mgm, Mgf, Pgm, Pgf, Siblings)

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Alcoholism			Gout			Seizure or epilepsy		
Anemia			Hemophilia			Sickle Cell Anemia		
Asthma			Hay Fever			Skin Disorders		
Cancer			Heart Disease			Stroke		
Diabetes			High Blood Pressure			Thyroid Disorders		
Gallbladder Disease			Hypoglycemia			Tuberculosis		
Glaucoma			Mental Illness			Venereal Disease		

Any other significant family health problems? _____

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Health Information

Hospitalizations/Surgeries: (Dates and type of illness/operation)

_____

_____

Known Allergies: (to medications, foods, pollens, etc.)

_____

_____

Medications (include prescription and non-prescription items, dosage and frequency of use.)

_____

_____

_____

Supplements: (include vitamins, herbs, minerals, etc.)

_____

_____

_____

Dietary Habits:

How many meals do you generally eat per day? _____ How many snacks? _____

What kinds of foods make up your primary diet? _____

Review Of Systems/Chinese Medicine 10 Questions

HOT/COLD/BODY TEMP

Do you have the following? ☐ Chills ☐ Fever ☐ Chronic fever ☐ Alternating Chills with Fever ☐ Night Sweats

☐ Warm hands and feet ☐ Cold hands and feet ☐ Hot flashes in the afternoon or evening

Describe your body temperature normally? ☐ Chilly ☐ Warm ☐ Neutral

HEENT

Which best describes your Headaches if applicable? ☐ Worse with fatigue ☐ One-Sided ☐ At Temples ☐ At Forehead

☐ At top of the head ☐ At back of head ☐ With Dizziness

Do you have the following? ☐ Dry eyes ☐ Watery eyes ☐ Blurred Vision ☐ Red Eyes ☐ Floaters ☐ Itchy Eyes

☐ High pitched ringing in the ears ☐ Low pitched ringing in the ears ☐ Difficulty Hearing ☐ Vertigo

☐ Dry Mouth ☐ Difficulty Swallowing ☐ Sensation of something stuck in throat ☐ Hoarseness

Which tastes if any do you have in your mouth? ☐ Bitter ☐ Sweet ☐ Sour ☐ Salty ☐ Pungent ☐ Metallic

Do you have? ☐ Stiff Neck ☐ Sore Throat ☐ Nose Bleeds ☐ Hearing Loss ☐ Dental Problems ☐ Sinus Drainage

☐ Sinus Pressure/Pain ☐ Runny Nose

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CHEST (Respiratory/Cardiac)

Please check all, if any, that apply: ☐ Chest Pain ☐ Palpitations ☐ Heavy Sensation in Chest ☐ Shortness of Breath ☐ Irregular Heartbeat ☐ Exercise Intolerance ☐ Leg Swelling ☐ Asthma ☐ Wheezing ☐ Frequent Respiratory Infections ☐ Dry Cough ☐ Productive Cough

DIET

I would describe my diet as? (Check all that Apply)

☐ Standard American Diet ☐ Fast Food and Processed Foods ☐ Organic Whole Foods Diet ☐ Meat and Potatoes ☐ Vegetarian ☐ Gluten-Free ☐ Dairy-Free ☐ Balanced Whole Foods, Lean Proteins & Vegetables

THIRST/WATER INTAKE

Thirst? ☐ Low ☐ Moderate ☐ High I prefer: ☐ Cold drinks ☐ Warm drinks ☐ Room temperature

How many cups (12 oz.) of water do you drink per day? ☐ 1-4 ☐ 5-8 ☐ 8-10 ☐ More than 10

APPETITE/DIGESTION (Gastrointestinal)

Describe your appetite? ☐ Low ☐ High ☐ Normal

I crave the following foods? ☐ Sugary ☐ Salty ☐ Fatty ☐ Cold ☐ Hot ☐ Spicy ☐ Sour

I suffer from ☐ Gas ☐ Bloating ☐ Abdominal pain/discomfort ☐ Belching ☐ Acid Reflux ☐ Nausea ☐ Abdominal Pain ☐ Hemorrhoids ☐ Vomiting

STOOLS

Do you have? ☐ Constipation ☐ Loose Stools with undigested food ☐ Loose stools (before menses) ☐ Diarrhea ☐ Sticky stools ☐ Early morning diarrhea ☐ Alternating diarrhea and constipation ☐ Hard stools ☐ Bloody or Black Stools

URINATION

Do you suffer from ☐ Painful urination ☐ Incontinence ☐ Urinary frequency ☐ Frequent UTI ☐ Kidney stones ☐ Diminished force of urinary stream ☐ Difficulty starting or stopping flow

Urine color is ☐ Dark ☐ Pale yellow ☐ Clear

SWEAT

I sweat/perspire? ☐ Seldom ☐ Moderately ☐ Often ☐ Excessively

I perspire in the area(s) of? ☐ Head ☐ Entire Body ☐ Under arms ☐ Other _____

MUSCULOSKELETAL/PAIN

Do you have any of the following? ☐ Joint Pain/Stiffness ☐ Joint Swelling ☐ Back Pain ☐ Muscle Weakness ☐ Muscle Spasm/Cramps

Do you have Pain? ☐ Yes ☐ No If yes, what is the location of pain? _____

Which describes your pain? ☐ Better with heat ☐ Better with pressure ☐ Worse with heat ☐ Worse with pressure

Seizurea

☐ Worse with damp weather ☐ Pain moves from place to place ☐ Pain worse with fatigue

☐ Pain associated with bloating or distention ☐ Sharp ☐ Stabbing ☐ Burning ☐ Dull ☐ Achy

Do you experience numbness or tingling in the hands or feet? ☐ No ☐ Yes If yes, explain_____

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NEURO

Do you have the following symptoms? ☐ Seizures ☐ Fainting ☐ Dizziness ☐ Limb Weakness ☐ Balance Issues ☐ Tremors ☐ Rigidity ☐ Limb Numbness ☐ Swallowing Difficulty

SLEEP

Do you have the following? ☐ Difficulty falling asleep ☐ Waking at night due to heat ☐ Nightmares ☐ Waking or difficulty falling asleep because mind racing ☐ Insomnia of unknown reason ☐ Unrefreshing sleep

ENERGY

Typically my energy level is (0-10/10 ten is great energy, zero is no energy)_____
I am ☐ able to accomplish daily tasks ☐ struggle to accomplish daily tasks ☐ unable to accomplish daily tasks

EMOTIONS/MOOD

Do you have the following? ☐ Depression ☐ Anxiety ☐ Irritability ☐ Mania ☐ Anger/Agression ☐ Suicidal Thoughts ☐ Other_____

FEMALES

If Menstruating:

LMP _____Days between Cycles? _____How long do your periods Last? _____

Clots? ☐ No ☐ Yes If yes, size? ☐ Dime ☐ Nickel ☐ Quarter ☐ Half Dollar ☐ Larger than ½ Dollar

Cramps? ☐ Mild ☐ Moderate ☐ Severe Pain Quality? ☐ Stabbing ☐ Burning ☐ Achy ☐ Bear down Sensation

Do you have vaginal Discharge? ☐ No ☐ Yes

If **yes**, is it? ☐ Thin ☐ Thick ☐ Clear ☐ White ☐ Yellow ☐ Scanty ☐ Copious

Color of Menses? ☐ Dark Red ☐ Bright Red

Do you have PMS symptoms? ☐ No ☐ Yes if yes, answer the questions below:

Premenstrual symptoms before your period (Mark below): (Grade intensity – 1=mild, 2=moderate, 3=severe)

___ Breast Tenderness ___ Bloating ___ Skin ___ Mood Changes _____
___ Headache ___ Cramping ___ Diarrhea ___ Appetite Changes _____
___ Low Back Pain ___ Constipation ___ Other

PMS symptoms occur? ☐ One week prior ☐ 2 weeks prior ☐ Few days prior ☐ Other _____

Do the above premenstrual symptoms get better with your period? ☐ No ☐ Yes

Are You Post-Menopausal? ☐ No ☐ Yes

Do you have the following symptoms now?

Hot flashes? ☐ No ☐ Yes Night Sweats? ☐ No ☐ Yes Insomnia? ☐ No ☐ Yes
Vaginal Dryness? ☐ No ☐ Yes Low Libido? ☐ No ☐ Yes

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YOUR SKIN

YOUR SKIN TYPE/HISTORY

What is your skin type? ☐ Normal ☐ Oily ☐ Dry ☐ Sensitive ☐ Acne Prone ☐ Combination (oily in T=Zone)

Do you have any of the following conditions? ☐ Rashes/Hives ☐ Eczema ☐ Ulcers ☐ Psoriasis ☐ Lesions/Moles/Warts

What skin care products are you currently using? ☐ Soap ☐ Cleanser ☐ Toner/Astringent ☐ Moisturizer ☐ Masque ☐ Exfoliator ☐ Eye Care ☐ Sunscreen ☐ Other_____

What brand name of products for your skin do you currently use? _____

Have you ever experience ACNE breakouts? ☐ No ☐ Yes ☐ Occasionally

After 20 minutes in the sun do you? ☐ Always Burn ☐ Usually Burn ☐ Sometimes Burn ☐ Rarely Burn ☐ Never Burn

Have you had any of the following treatments? ☐ Microderm ☐ Chemical Peel ☐ Laser ☐ Resurfacing Treatment ☐ Peel ☐ Other_____

Do you have a tendency to scar? ☐ No ☐ Yes

Do you have any special areas of concern pertaining to your skin/face/neck? ☐ No ☐ Yes

If yes, please explain _____

Do you bruise easily? ☐ No ☐ Yes

Do you take any medications that thin your blood? ☐ No ☐ Yes Explain: _____

SKIN TREATMENT HISTORY

Have you ever received facials before? ☐ No ☐ Yes

Have you ever had acupuncture before? ☐ No ☐ Yes Have you ever had **facial acupuncture** before? ☐ No ☐ Yes

Have you been under a dermatologist or other physician's care over the past year for your skin? ☐ No ☐ Yes

If so, please explain for what and by whom you were treated? _____

Are you allergic to any known skin care ingredients? ☐ No ☐ Yes Explain _____

Have you received Botox? ☐ No ☐ Yes When was the last date of your treatment? _____

Are you currently using any of the following products? ☐ Glycolic Acid ☐ Salicylic Acid ☐ Exfoliating Scrubs ☐ Hydroxy Acid Products ☐ Cortisone ☐ Cleocin-T ☐ Sulphur ☐ Lactic Acid ☐ Vitamin A Derivatives (Example:Retinol)

Have you bleached your skin? ☐ No ☐ Yes

If so what was the last product you used? _____

When was the last treatment? _____

Have you had any skin care treatment in the last 14 days? ☐ No ☐ Yes

If yes what type of treatment did you have? _____

YOUR SKIN CARE GOALS

What skin conditions do you want to improve?

☐ Acne/breakouts ☐ Enlarged Pores ☐ Rosacea ☐ Dehydration ☐ Sun Damage ☐ Uneven Texture or Tone ☐ Hyper pigmentation (i.e. Age spots) ☐ Fine Line and Wrinkles Around Eyes ☐ Fine Line and Wrinkles Around Mouth ☐ Loose Skin of the Neck ☐ Fine Line and Wrinkles Around Eyes ☐ Other _____

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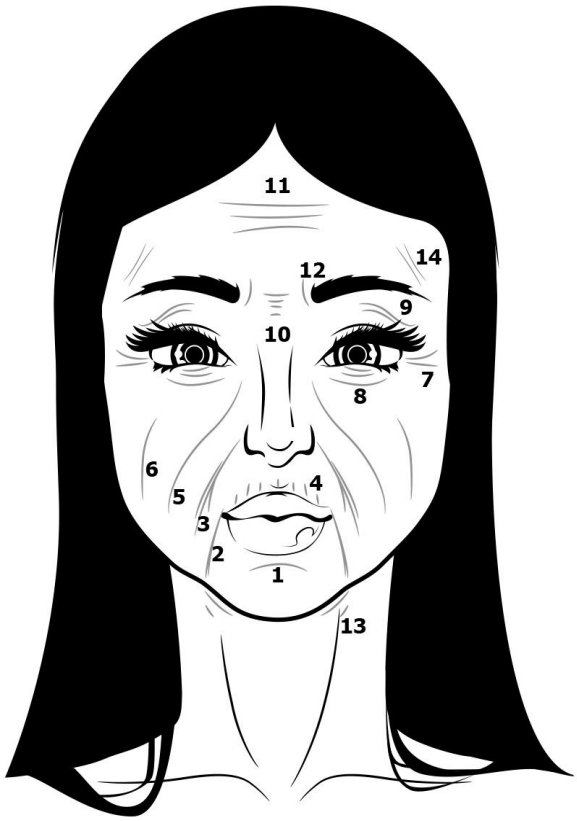
Face Map

Indicate with the picture below the corresponding number for the top 3 areas you want to work on in order of priority (#1 = top priority). We will focus on the top two areas per each acupuncture 12 week series.



#1 Problem Area_____

#2 Problem Area_____

#3 Problem Area_____