Vince Link, O.M.D.
Acupuncture & Herbal Medicine

2920 S. Rainbow Blvd., Suite 140
Las Vegas, NV 89146
(702) 444-4775

# Patient Intake Form

Date: ____________

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held **absolutely** confidential. If you have qustions, please ask. Thank you.

| | | | |
|---|---|---|---|
| Name: | | Male | Female |
| Street | Age Ht. | Wt. | |
| City | Occupation | S.S. # | |
| State Zip | Phone-Home: | Work: | |
| Date of Birth: | Marital Status: | # of children: | |

Family Physician

In Emergency Notify

Referred By

Have you been treated by acupuncture before?

Insurance: Yes _______ No _______

Does your insurance cover acupuncture? Yes _______ No _______

Name of Insurance Company

**Main problem(s)** you would like us to help you with.

How long ago did this problem begin (be specific)?

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?

Is your problem work related? Explain.

Have you been given a diagnosis for this problem? Is so, what?

What kind of treatment have you tried?

**Past medical history** (please include date):

**Significant Illnesses:** Cancer Diabetes Hepatitis High Blood Pressure
Heart Disease Rheumatic Fever Thyroid Disease Seizures Venereal Disease
Other (please specify) HIV

**Surgeries:**

**Significant Trauma** (auto accidents, falls, etc.)

**Birth History:** (prolonged labor, forceps delivery, etc.)

**Allergies:** (drugs, chemicals, foods.)

**Family Medical History:** ___

Diabetes | Cancer | High Blood Pressure | Seizures | Asthma | Allergies

Heart Disease | Stroke | Alcoholism | Miscarriage | Other (please specify)

**Occupation** ___

**Occupational stress (chemical, physical, psychological, etc.)**

**Do you have a regular exercise program? Please describe.**

**Medicines** taken within the last two months ___
(include vitamins, over-the-counter drugs, herbs, etc.)

Are you or have you ever been on a restricted diet? What kind?

Please describe your average daily diet:
Morning | Afternoon | Evening

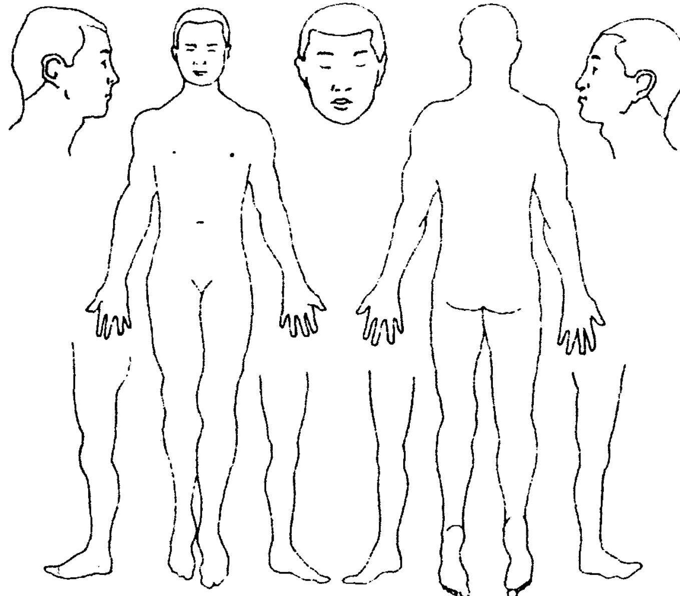
Do you smoke cigarettes? yes _____ no _____ If so, how many per day?

How much coffee, tea, or cola do you drink per week?

How much alcohol do you drink per week?

Please describe any use of drugs for non-medical purposes.

**Indicate painful or distressed areas** ___



**Please check if you have had** (in the last three months):

## General

- ☐ Poor Appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold or hot drinks)
- ☐ Sudden energy drop (What time of day)?
- ☐ Desire hot food
- ☐ Desire cold food
- ☐ Poor Sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Weight loss
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain

Favorite time of year ____________________

Worst time of year ____________________

## SKIN AND HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of Hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Purpura

Any other hair or skin problems?

## HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color Blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue

Headaches (Where and When)?

Any other head or neck problems?

## CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest Pain?
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty in breathing

Any other heart or blood vessel problems?

## RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm  What color?
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath

Any other lung problems?

## GASTROINTESTINAL

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad Breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

Any other problems with your stomach or intestines?

- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Parasites

- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids

Bowel Movement:
Frequency ____________
Color ____________
Odor ____________
Texture/Form ____________

## GENITO-URINARY

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals

Do you wake up to urinate? How often?
Any particular color to your urine?
Any other problems with your genital or urinary system?

## MALE:

- ☐ Prostate
- ☐ Fertility problems
- ☐ Painful/swollen testicles
- ☐ Discharge
- ☐ Ejaculation problems

## FEMALE: [PREGNANCY AND GYNECOLOGY]

_______ Number of Pregnancies
_______ Number of births
_______ Miscarriages
_______ Abortions
_______ Premature births
_______ Cesareans
_______ Difficult pregnancies/births

First date of last period ____________
Age at first menses ____________
Duration of periods ____________

- ☐ Unusual character (heavy or light)
- ☐ Painful periods-abdomen ___ back ___
- ☐ Clots
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation. If so, what?
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Endometriosis
- ☐ Breast masses
- ☐ Ovarian cysts
- ☐ Fertility Problems
- ☐ Hot flashes

Date of last pap smear ____________
Do you practice birth control? ____________
What type and for how long? ____________
Other ____________

## MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Hip pain
- ☐ Hernia

Any other joint or bone problems?

## NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety

Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?
Any other neurological or psychological problems?

The above information is true to the best of my knowledge.

Signature ________________________________

Please tell us of any other problems you would like to discuss:

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## Consent for Treatment

I, the undersigned, understand that treatment may include the use of acupuncture needles, laser acupuncture, moxibustion, cupping, mineral heat lamps, herbal formulas (raw, pill, capsule, syrup, tincture, lotion, plaster, ointment, powder, and suppository), electrical stimulation, and diet and nutritional counseling. Examinations are usually done routinely to determine the nature and extent of the problem.

I understand the risks of treatment, although limited, could include the following: burns from a mineral heat lamp, cupping, and moxibustion; bruising; puncturing organs in the abdomen and chest cavities; shock induced by needle stimulation; premature labor in pregnant females; herbal side effects (drug interactions or allergic reaction). (Some herbs and acupuncture points should not be used with pregnant females). If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs or any drugs, am pregnant or suspect that I am pregnant, **I agree that I will inform the practitioner before beginning the treatment.** I understand that slight bruising or skin irritation from cupping or needles is a normal side effect.

I understand that Traditional Chinese Medicine may effect people on all levels: physical, emotional, mental, and spiritual because it works within the entire body to restore balance. I understand that the duration of treatment varies person to person depending on the specific illness and body constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatment, and I do not hold Dr. Vince Link responsible for any risks that may come about due to treatment. I understand that the practitioner can not be held liable for any intentional misrepresentation by me or any other patients, i.e. not advising that I am HIV positive or pregnant, etc…

I understand and accept the risks involved in treatment.

______________________________ ______________

Patient's Signature (Parent or guardian if under 18) | Date