BENJAMIN ZAPPIN, L.Ac.
Acupuncture & Herbal Medicine

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Intake form

Please provide the following information and email to benzappin@gmail.com or bring to your first appointment.

Name Gender

Address

Telephone/fax Email

Date of birth Height and weight

Number of children

Occupation

Physical activities you engage in:

How or from whom did you hear about Benjamin?:

Medical doctor or other practitioner:

Please list all medications, including herbs and vitamins you are presently taking, or therapies you are presently undergoing:

Have you ever undergone herbal therapy before?

Do you generally respond well to medical treatments, medicines, therapies, etc.?

A. PRIMARY CONCERN --- (Describe your symptoms to the best of your ability):

B. SECONDARY CONCERN(S) --- (List any other symptoms you are experiencing regardless of whether it seems related to your primary complaint):

When did you first notice it? A _______ B _______

How long has is been occurring? A _______B _______

When and under what circumstances does it seem to improve? A _______B _______

Have you been treated by anyone else for this condition? A _______B _______

If so, when and by whom?

Medical History (List all past illnesses, injuries and operations):

Medical History of Relatives (briefly): Grandparents, Parents, Aunts/Uncles, Siblings, Children

Blood Type?

Ancestry? (What part of the world your parents/grandparents came from):

Check if you have experienced any of the following conditions:
If you have in the past, use a **P**, if recently use an **R**, if frequently also include an **F**.

_____Chronic pain (where?) _____Acute/temporary pain (where?)
_____HBP _____Hypoglycemia _____Low Body Temp. _____LBP _____Epilepsy
_____Gallstones _____Heart problems _____Nervous Complaints _____Kidney Stones
_____Shortness of breath _____Spasms/twitches
_____Hepatitis (specify A, B, C & dates)
_____Asthma _____Bloatedness _____Carcinoma (specify location)
_____Allergies
_____Sleepiness after meals _____Cancer (specify location and type)
_____Sinus infections
_____Enlarged lymph nodes _____Low back pain _____Headaches
_____Enlarged spleen
_____Frequent urination _____Frequent colds & flus _____Enlarged Liver
_____Night time urination _____Poor memory _____Mononucleosis
_____Teeth problems
_____Cold Hands and Feet _____Hearing Difficulties _____Thyroid Problems (specify)
_____Undigested food in stools _____Constipation _____Eyesight difficulties
_____Loose stools
_____Depression _____Glandular problems (specify) _____TB _____Over-excitable
_____Mood Swings _____Anemia _____Diarrhea _____PMS _____Diabetes
_____Tight neck/shoulders _____Disability of hips _____Disability of back
_____Disability of knees _____Disability of ankles _____Other (specify)

How would you describe your energy level?

High ___________ Low ___________ Up and down ____________

How would you describe your sex drive?

High __________Low ___________ Up and down ____________

Do you get gas and/or bloatedness?

Bowel Movements: Are they regular? (daily) ____ Frequency:

Consistency and color: ______________

Mucus or blood in the stools? _____

Urine: Is your urinary frequency more than 6x/day or less than 4x/day?

Color __________Odor ______________ Other __________ _________

Do you experience nighttime urination? Number of times/night?

How would you describe your sleep?

How is your memory?

How would you describe the stress level in your life?

Home _______Work _______Other _________

Do you have an unusual susceptibility to heat or cold?

Do you sweat easily or at night?

What temperature do you prefer in terms of climate and foods?

What is (are) the predominant emotion(s) you experience?

Are you content with your life? Home? Work? Social? Other?

What are your strengths?

What are your weaknesses?

Please describe any emotional issues you have in terms of your family, work and social relationships:

Do you use alcohol, cigarettes, soda, sugar, coffee, marijuana, cocaine or any other recreational drug? (specify frequency and quantity):

Would you consider yourself to have a sugar, caffeine, nicotine or drug addiction?

Do you have a strong preference for, or aversion to, any foods or drinks? (specify):

What particular diet or nutritional program do you follow? (Example: vegetarian, macrobiotic, meat & potatoes, etc.)

Do you generally cook your own food?

Where do you shop for your food?

Please describe your general diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

For Women:

What is the length of your menstrual cycle?

What is the length of your menses itself?

Do you ever experience PMS? Cramping? If so when? Clotting? Light flow? Excessive flow?

List the dates and years of any children you have birthed and if they were normal deliveries: