



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 it 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 _____ Bloating _____ 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: