RIPPLE
WELLNESS FOR ALL

ACUPUNCTURE INTAKE

Welcome! Thank you for choosing Ripple for your health care needs. We are here to help and are excited to share our passion for healing.

We appreciate you taking a few minutes to fill out these forms. This information gives us a comprehensive picture of your health status and improves our ability to address your health concerns. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date:	Name:	Date of Birth:

Please briefly describe your primary complaint (e.g. "knee pain", "depression", "back pain"):

Please describe any secondary complaints:

If you were treated, by self or a doctor, what method or medicine was used? What results?

Are you under the care of a health care practitioner(s)? ☐ No ☐ Yes
If yes, please list them and explain:

Are you currently under the care of or have you been treated in the past by a Chinese medicine practitioner? ☐ No ☐ Yes If yes, please give the names of provider and dates of treatment:

Have you had diagnostic imaging related to any of your complaints?
(X-Ray, Ultrasound, Laparoscopy, CT Scan, MRI, Other) ☐ No ☐ Yes If yes, please list:

Please list any medical issues that other healthcare providers have diagnosed:

Please list any surgeries you have had: (year and reason for surgery)

Other Hospitalizations:

CHILDHOOD ILLNESS
☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other

List any allergies as a child:

WOMEN: Are you pregnant or planning to become pregnant soon? ☐ No ☐ Yes

Current Medications/Supplements/Herbs	Dosage

Other medications taken in the past 3 months:

Do you have any allergies to medications, supplements, or herbs? ☐ No ☐ Yes If yes, please list:

Are there any activities you do that expose you to physical harm? ☐ No ☐ Yes
(e.g. fumes, pollutants, chemicals, mechanical injury, loud noise, heat, repetitive stress, radiation, sun, animals, etc.)
If yes, please explain:

Are there any activities <u>in the past</u> that exposed you to hazards, such as those above? ☐ No ☐ Yes
If yes, please explain:

Please describe what you ate and drank, including water, in the last 24 hours:

Morning	Daytime	Evening

Caffeine Consumed	Coffee	Tea	Soft Drinks
Number of Cups/Cans Daily			

Do you drink alcohol? ☐ No ☐ Yes How many drinks per week? ______________________________

Have you ever smoked cigarettes or consumed tobacco products regularly? ☐ No ☐ Yes

Did you quit? ☐ No ☐ Yes When did you quit? ______________________________

Do you use recreational drugs or pharmaceutical drugs not as they are intended? ☐ No ☐ Yes

What type? ______________________________ For how long? ______________________________

Have you ever been treated for drug or alcohol dependence? ☐ No ☐ Yes

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FAMILY HEALTH HISTORY

Please indicate any incidence in your family (immediate and extended):

Heart Disease:
Cancer:
Diabetes:
Major Genetic Illness
Any Condition Related to Your Complaints:

REVIEW OF SYSTEMS

PAIN

C	P	(Current/Past)
☐	☐	Pain that is Better with Heat
☐	☐	Improved with Pressure/Massage
☐	☐	Aggravated by Pressure
☐	☐	Aggravated by Damp or Cold Weather
☐	☐	Sharp or Stabbing Pain
☐	☐	Pain that Changes Location
☐	☐	Dull Pain, Worse with Fatigue
☐	☐	Chronic Back Pain
☐	☐	Acute Back Pain

CHEST AND ABDOMEN

C	P	(Current/Past)
☐	☐	Pain in the Chest Area
☐	☐	Pain in the Chest with Cough
☐	☐	Pain Over the Ribs
☐	☐	Pain Just Below the Ribs
☐	☐	Pain in the Upper-Middle Abdomen
☐	☐	Pain in the Lower Abdomen
☐	☐	Heart Palpitations

DIZZINESS

C	P	(Current/Past)
☐	☐	With Loss of Balance
☐	☐	With Heavy/Muzzy Feeling in the Head
☐	☐	Worse with Fatigue
☐	☐	Sudden Onset
☐	☐	Gradual Onset

SWEATING

C	P	(Current/Past)
☐	☐	Sweat w/Little or No Exertion
☐	☐	Night Sweats

SLEEP

C	P	(Current/Past)
☐	☐	Hard to Fall Asleep, but Sleep Well
☐	☐	Nightmares or Violent Dreams
☐	☐	Wake Up Too Early

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HEAT, COLD, FEVER, CHILLS

C	P	(Current/Past)
☐	☐	Frequently Cold/Chilled
☐	☐	Get Hot at Night
☐	☐	Alternating Between Fever & Chills
☐	☐	Fever, Worse in the Afternoon
☐	☐	Constant Low Grade Fever
☐	☐	Feel Hot But Don't Have a Fever
☐	☐	Significant Sweating with Cold/Flu
☐	☐	No Sweating with Cold/Flu
☐	☐	Oily, Beaded Sweat on Forehead
☐	☐	Entire Body Sweaty w/Low Exertion
☐	☐	Sweating on Palms, Soles, or Chest
☐	☐	Don't Sweat Much, Even w/Activity
☐	☐	Feet Cold but No Cold/Flu
☐	☐	Cold Hands/Feet
☐	☐	Swollen Hands/Feet

HEADACHE

C	P	(Current/Past)
☐	☐	Chronic Headaches
☐	☐	Severe Headaches
☐	☐	Dull Pain
☐	☐	Distending/Throbbing Pain
☐	☐	Stabbing/Boring Pain
☐	☐	Worse in Cold or Windy Weather
☐	☐	Worse with Fatigue
☐	☐	Feels Heavy/Foggy/Damp
☐	☐	Frontal/Sinus/Brow/Side of Head
☐	☐	Over the Temples/Crown of Head
☐	☐	Base of the Skull in Back
☐	☐	Worse During the Day
☐	☐	Worse During the Evening

THIRST/MOUTH

C	P	(Current/Past)
☐	☐	Lack of Thirst
☐	☐	Desire for Hot Drinks
☐	☐	Strong Thirst
☐	☐	Prefer Cold Liquids
☐	☐	Dry Mouth but Sip Drinks Slowly
☐	☐	Thirsty, but No Desire to Drink
☐	☐	Mouth (Canker) Sores/Tongue Sores
☐	☐	Bad Breath
☐	☐	Bleeding/Painful Gums

APPETITE

C	P	(Current/Past)
☐	☐	Lack of Appetite
☐	☐	Insatiable Appetite
☐	☐	Fullness/Bloating/Distention After Eating
☐	☐	Preference for Warm Food
☐	☐	Preference for Cold Foods
☐	☐	Bitter Taste in the Mouth
☐	☐	Metallic Taste in the Mouth

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EYES			EARS		
C	P	(Current/Past)	C	P	(Current/Past)
☐	☐	Eye Pain, Swelling, Redness	☐	☐	Sudden Onset Tinnitus (Ringing)
☐	☐	Blurred Vision or "Floaters"	☐	☐	Chronic Tinnitus
☐	☐	Dry Eyes	☐	☐	Sudden Onset Deafness
☐	☐	Yellow Sclera (The "Whites")	☐	☐	Gradual Onset Deafness
☐	☐	Abnormal Eye Movement			

URINE			STOOLS/DIGESTION		
C	P	(Current/Past)	C	P	(Current/Past)
☐	☐	Lack of Bladder Control/Urgent Urination	☐	☐	Constipation
☐	☐	Retention or Incomplete Urination	☐	☐	Constipation/Dry Stools
☐	☐	Pain/Burning/Stinging with Urination	☐	☐	Small Stools
☐	☐	Very Pale (Clear) Urine	☐	☐	Infrequent/Not Dry Stools
☐	☐	Dark Yellow/Cloudy/Red Urine	☐	☐	Chronic Diarrhea
☐	☐	Frequent or Copious Urination	☐	☐	Diarrhea After a Meal
☐	☐	Scanty/Difficult Urination	☐	☐	Early Morning Diarrhea
☐	☐	Get Up More Than Once to Urinate	☐	☐	Discomfort Improves After Bowel Movement
			☐	☐	Bloating or Gas After Eating
			☐	☐	Stomach Pain
			☐	☐	Tired After Eating
			☐	☐	Acid Reflux

OTHER					
C	P	(Current/Past)			
☐	☐	Fatigue	☐	☐	Skin Rashes Where? ______________________
☐	☐	Mental Fogginess	☐	☐	Numbness Where? ______________________
☐	☐	Restlessness/Anxiety	☐	☐	Spasm/Twitching/Cramping Where? ______________________
☐	☐	Swollen Hands/Feet			
☐	☐	Seizures/Convulsions			
☐	☐	Memory Problems			
☐	☐	Hair Loss			

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WOMEN		
C	**P**	**(Current/Past)**
☐	☐	Abnormal PAP
☐	☐	Birth Control
		Type ______________________________
☐	☐	Breast Lumps
☐	☐	Cervical Dysplasia
☐	☐	Vaginal Discharge
☐	☐	Clotting
☐	☐	Cramping w/Menses
☐	☐	Difficulty Getting Pregnant
☐	☐	Endometriosis
☐	☐	Heavy Menstrual Flow
☐	☐	Scanty Menstrual Flow
☐	☐	Hormone Replacement
☐	☐	Hysterectomy/Oophorectomy
☐	☐	Irregular Cycles
☐	☐	Menopausal Symptoms
☐	☐	Uterine Fibroids
☐	☐	Ovarial Cysts (PCOS)
☐	☐	Painful Intercourse
☐	☐	Painful Periods
☐	☐	Premenstrual Syndrome (PMS)
☐	☐	Spotting Between Periods
☐	☐	Sexually Transmitted Infection
		Type______________________________

MEN		
C	**P**	**(Current/Past)**
☐	☐	BPH
☐	☐	Ejaculation Concerns
☐	☐	Fertility Concerns
☐	☐	Impotence
☐	☐	Prostate Disease
☐	☐	Testicular Masses
☐	☐	Testicular Pain
☐	☐	STD
		Type______________________________

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Responsible Party Signature **Date**

Thank you for taking the time to fill out these forms.
I am looking forward to working with you!

Jeff Olson, L.Ac., MAcOM   Kate Sydney, L.Ac., MSOM

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