

# Gateway to Health Acupuncture

Ron Riskin L.Ac., CMT  
206 West Anapamu St.  
Santa Barbara, CA 93101  
(805) 963-9429  
acusurfdoc@cox.net

## Patient Information Sheet

CONFIDENTIAL

### Patient Information

Last Name:	First Name	Middle:
Address:		
City:	State:	Zip:
Tel. - Home:	Work:	Mobile:
Fax:	E-mail:	
Would you like to receive e-mail reminders prior to appointments? <input type="checkbox"/> Yes. <input type="checkbox"/> No.		
Date of Birth:	Age:	Occupation:
Employment Status (check all that apply): <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student		
Emergency Contact:	Relationship:	Phone:
Social Security #	Height:	Weight:
How did you hear about Gateway to Health Acupuncture:		
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other: _____		

***Confidentiality:*** Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.

### Primary Care Physician Information

Primary Physician:	Telephone:
Physician's Address (or name of clinic/hospital):	

### Insurance Information (if applicable)

Insurance Company:	Policy Holder Name:	Birth Date: ____/____/____	Relationship to Patient:
Insurance Company Address:		Telephone:	
Policy # / ID #:		Group #:	

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## Patient Intake Form

Patient \_\_\_\_\_ Date \_\_\_\_\_

Major Complaint(s), in order of importance to you:

	Severe	Moderate	Slight		How Long?	Pain Level (1-10)
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

FAMILY HISTORY: Complete for each family member, placing an **X** in the appropriate box.

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							
Other							

TRAVEL – Have you ever traveled or lived outside of the U.S?  Yes  No

Any health problems when abroad?  Yes  No If yes, what? \_\_\_\_\_

<b>MEDICATIONS</b> – Please list all prescription medications you use. Include those you may only use occasionally. Remember inhalers, eye drops, nose drops.					
Prescription Name	Purpose	How long	Dose	How often	Last Dose

Patient \_\_\_\_\_ Date \_\_\_\_\_

MEDICAL CONDITIONS – Please list conditions & surgeries you have or have had and year diagnosed.		ALLERGIES Medications, Seasonal, Environmental, Food	OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:
Year	Condition/Surgery		Occupation
			<input type="checkbox"/> Stress
			<input type="checkbox"/> Heavy Typing/Computer Use
			<input type="checkbox"/> Hazardous Substances
			<input type="checkbox"/> Heavy Lifting
			<input type="checkbox"/> Other

**SYMPTOMS – For each symptom you currently have, rate its severity from 1-3 (3 being worst). Leave blank if N/A.**

<b>LV/GB</b>	<b>HT/SI</b>	<b>SP/ST</b>
<input type="checkbox"/> Irritability	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Heaviness anywhere in body
<input type="checkbox"/> Depression	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hard to get up in the morning
<input type="checkbox"/> Visual problems	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Edema (swelling)
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Easily startled	<input type="checkbox"/> Muscles feel tired often
<input type="checkbox"/> Dry/itching eyes	<input type="checkbox"/> Restlessness/agitation	<input type="checkbox"/> Easy bruising and bleeding
<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Bad breath
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Breathlessness	<input type="checkbox"/> Low appetite
<input type="checkbox"/> Feeling of lump in throat	<input type="checkbox"/> Vivid dreams	<input type="checkbox"/> Snacking
<input type="checkbox"/> Clenching of teeth at night	<input type="checkbox"/> Dreams are bothersome	<input type="checkbox"/> Tendency towards hypoglycemia
<input type="checkbox"/> Muscle cramping	<input type="checkbox"/> Lack of joy in life	<input type="checkbox"/> Difficulty digesting oily foods
<input type="checkbox"/> Muscle twitching	<input type="checkbox"/> Laughing for no reason	<input type="checkbox"/> Nausea
<input type="checkbox"/> Joints feel tight/stiff	<input type="checkbox"/> Craving/avoiding bitter foods	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Cold hands/feet		<input type="checkbox"/> Gas/belching
<input type="checkbox"/> Soft/brittle nails	<b>LU/LI</b>	<input type="checkbox"/> Bloating
<input type="checkbox"/> Craving/avoiding sour foods	<input type="checkbox"/> Dry cough	<input type="checkbox"/> Hemorrhoids
	<input type="checkbox"/> Cough with sputum	<input type="checkbox"/> Constipation
<b>KD/UB</b>	<input type="checkbox"/> Nasal discharge	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Poor sense of smell	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Indigestion/heartburn
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Itchy, red or painful throat	<input type="checkbox"/> Over-thinking
<input type="checkbox"/> Weakness/pain in lower back	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Tendency to become obsessive
<input type="checkbox"/> Aching bones	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Craving/avoiding sweets
<input type="checkbox"/> Feel cold easily	<input type="checkbox"/> Itchy skin	
<input type="checkbox"/> Low sexual energy	<input type="checkbox"/> Grief, sadness	<b>OTHER</b>
<input type="checkbox"/> Excess sexual desire	<input type="checkbox"/> Shortness of breathless	_____
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Allergies	_____
<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Low resistance to colds or flu	_____
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Low physical stamina	_____
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Mild fever comes and goes	_____
<input type="checkbox"/> Craving/avoiding salty foods	<input type="checkbox"/> Craving/avoiding spicy foods	_____

Patient \_\_\_\_\_ Date \_\_\_\_\_

<b>HABITS – Please check any habits which apply to you now or in the past</b>			
Coffee	<input type="checkbox"/> Yes <input type="checkbox"/> No	# per day _____	age started _____ age quit _____
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	# per day _____	age started _____ age quit _____
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No	# per day _____	age started _____ age quit _____
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	# per day _____	age started _____ age quit _____
Crack/Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No	# per day _____	age started _____ age quit _____
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No	# per day _____	age started _____ age quit _____

<b>FEMALES -</b>			
Form of birth control _____	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clotting	<input type="checkbox"/> Hot flashes
Last period _____	Last PAP test _____	<input type="checkbox"/> Heavy bleeding	<input type="checkbox"/> Vaginal dryness
Age started menstrual cycle _____	Age stopped _____	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Other _____
<input type="checkbox"/> Menstrual Pain	<input type="checkbox"/> Water retention	No. Pregnancies _____	_____
<input type="checkbox"/> Low backache	<input type="checkbox"/> Mood changes	No. Vaginal Deliveries _____	No. Miscarriages _____
<input type="checkbox"/> Irregular menses	<input type="checkbox"/> Painful breast	No. Cesareans _____	No. Abortions _____

Please describe any restricted diet you follow(ed) now or in the past \_\_\_\_\_  
\_\_\_\_\_

Please describe your typical daily diet -  
Breakfast \_\_\_\_\_ Morning Snack \_\_\_\_\_  
Lunch \_\_\_\_\_ Afternoon Snack \_\_\_\_\_  
Dinner \_\_\_\_\_ Evening Snack \_\_\_\_\_

Please describe any regular program of exercise - \_\_\_\_\_  
\_\_\_\_\_

Have you ever had an Acupuncture treatment? When and for what reason? \_\_\_\_\_  
\_\_\_\_\_