Acupuncture Intake Information
Lynnea Villanova, MD/ Pulse Medical

Please complete the following as best as you can. While some of the questions are very personal, this information is important to appropriately individualize your therapy.

Personal Information

Name **DOB**

Social Information

Occupation

With whom do you live spouse significant other alone roommate other

Medical Information

Allergies (food and drug)

Past Medical Issues *please include all childhood illnesses, infections, hospitalizations issues that has brought you to the doctor's office in the past, etc*

Current Stressors *please list the current stressful issues in your life, inc. chronic pain*

Emotional Make-Up *Please describe yourself emotionally. Please include how you express anger – e.g. short bursts, hold in, smolders for a while*

Family Medical History *please list the medical illnesses of your parents, sibs, and children*

Family Emotional History *please describe your parents natures, inc. how anger was expressed. Also list any signif. emotional issues of your sibs.*

Medications *please list all past and current medications – even short term ones*

Current

Preferences

Taste *of the following tastes, which one are you usually most drawn to*

Salty **Sweet** **Bitter** (coffee) **Sour** (citrus) **Spicy** (flavorful, savory)

Color *of the following colors, which one would you choose (e.g. clothes on a rack)*

Black/Blue **Green** **Red** **Yellow** **White**

Season *which is your favorite time of year*

Spring **Summer** **Fall** **Indian Summer** **Winter**

Climate *which is your favorite environment*

Warm/dry **Cool/dry** **Warm/moist** **Cool/moist**

What is your favorite time of day *when are you at your best*

System Review

please write the first thing that comes into your mind to describe the following parts of your body (eg – weak, strong, etc). If nothing comes to mind – write ok or fine, etc

Head/concentration	**Eyes/vision**
Ears/hearing	**Mouth/sores**
Nose	**Weight**
Perspiration level	**Sleep/trouble**
Smoking	**Urination**
Vaginal/penile discharge	**Teeth**
Skin	**Chest**
Bones	**Muscles**
Nails/ridges	**Warmth (tend to feel hot or cold)**
Hair/scalp	**Menstruation**
Pregnancies	**How much total fluid do you consume per day?**
Caffiene amt	**Diet/appetite**
Stomach/Intestines (const/diarrhea)	**Do you wear glasses?**

For Office Use Only

Morph	**Face**
Clothes	**Hair**
Movements	**Fr/ax**
Color predom	**hands**
Lips	**Sym**

Tongue 1) Vitality of Color **2) Body Color** **3) Body Shape** *Shape, surface, texture, involuntary movements*. **4) Coating** *Color, thickness, distrib, +/- root* **5) Moisture**			
Pulse			
TH	**MH**	**KI**	**BL**
ST	**SP**	**LV**	**GB**
LI	**LU**	**HT**	**SI**

Structural biopsychotype
Current Meridian Issue
Five Phases? Y N