Mountain Spirit Acupuncture
12201 Pecos Street Suite 100 Westminster, CO 80234
303-929-7334

Pregnancy Intake

Name: ______________________________ Birth Date: ____/____/____ Age: _____

Address: ______________________________ City: _______________ State: _______ Zip: ________

Preferred Phone #: ______________________ ☐ Home ☐ Cell ☐ Work Ok to leave messages? ☐ Yes ☐ No

How did you hear about **Mountain Spirit Acupuncture?** ☐ Friend – (Who?) ____________________ ☐ Internet
☐ Mail-out ☐ MD / Midwife ☐ Other ____________________

Emergency Contact: ____________________ Relation: ____________________ Phone #: ______________

Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally and emotionally. Please complete the following questionnaire as thoroughly as possible.

Are you currently receiving health care? ☐ Yes ☐ No
If yes, where and from whom? ______________________________
If no, when and where did you last receive health care? ______________________________

MAIN HEALTH CONCERNS

PRIMARY COMPLAINT: ______________________________
Symptoms: ______________________________
____
____
How long have you had this? ______________________________
Is your condition: ☐ Getting worse ☐ Staying constant ☐ Coming & going Have you had this in the past? ☐ Yes ☐ No
How did it begin? ______________________________
What aggravates it? ______________________________
What relieves it? ______________________________
What other healthcare practitioners have you seen about this? ______________________________
Type of care given? ____________________ Was it effective? ____________________

SECONDARY COMPLAINT: ______________________________
Symptoms: ______________________________
____
____
How long have you had this? ______________________________
Is your condition: ☐ Getting worse ☐ Staying constant ☐ Coming & going Have you had this in the past? ☐ Yes ☐ No
How did it begin? ______________________________
What aggravates it? ______________________________
What relieves it? ______________________________
What other healthcare practitioners have you seen about this? ______________________________
Type of care given? ____________________ Was it effective? ____________________

Are your complaints affecting your ability to work or otherwise be active? ☐ No effect ☐ Yes ☐ Some physical restrictions
☐ Need limited assistance ☐ Need assistance often ☐ Can't care for self

Is today's visit due to a Motor Vehicle Collision? ☐ Yes ☐ No If yes, when? ______________________________
Have you ever had acupuncture before? ☐ Yes ☐ No
Do you have any chronic infections diseases? ☐ Yes ☐ No If yes, explain: ______________________________
Are you suffering from any chronic illnesses? ☐ Yes ☐ No If yes, explain: ______________________________

Significant diseases, injuries, hospitalizations, surgeries, x-ray/CT/MRI/NMR

Reason Date Results (if applicable)

____
____
____
____

Please list any prescription medications, over the counter medications, vitamins or supplements that you are currently taking, and give your dosage.

Medication/Vitamin/Supplement Dosage Frequency Reason

____
____
____
____
____

Please list any foods, drugs, substances or medications you are hypersensitive or allergic to: ________________________________

Please check any immunizations that you have had: ◻ Polio ◻Tetanus ◻ Measles/Mumps/Rubella (MMR) ◻ Pertussis ◻ Diphtheria
◻ Hepatitis B ◻ Influenza ◻ Other: ____

Family History	Mother	Father	Brother(s)	Sister(s)
Age if living				
Health G = Good, P = Poor				
Age at death if deceased				
Cause of death				
Family Illnesses	Mother	Father	Brother(s)	Sister(s)
Allergies				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Stroke				
Mental Illness				

PLEASE FILL IN WHAT APPLIES TO YOU

◻ I am pregnant

◻ This is my first pregnancy

I'm carrying ◻ one ◻ twins ◻ more: _______

I'm due: _________________ I'm ________weeks Starting maternity leave: ___________________________________ (approx date)

◻ I'm planning on having a _______month maternity leave.

◻ I have birthed one or more babies in the past

	Youngest <--					> Oldest
Birth date:	_________	__________	__________	__________	__________	__________
Child's age:	_________	__________	__________	__________	__________	__________
Cesarean birth:	◻	◻	◻	◻	◻	◻
< 38 wks gestation	◻	◻	◻	◻	◻	◻
Birth was induced	◻	◻	◻	◻	◻	◻

CURRENT &/OR PAST PREGNANCIES

Please indicate any pregnancy complications that you have experienced (miscarriage, ectopic pregnancy, premature labor, (pre) eclampsia, gestational diabetes, etc): ____

Please indicate any conditions you have experienced either in this pregnancy (first box, C) or if you have experienced this condition prior to pregnancy (second box, P):

C / P
☐ ☐ Muscle cramps
☐ ☐ Headaches
☐ ☐ Carpal tunnel pain
☐ ☐ Sciatica
☐ ☐ Constipation/Gas
☐ ☐ Restricted breathing
☐ ☐ Swelling (edema)

C / P
☐ ☐ Varicose veins
☐ ☐ Sinus concerns
☐ ☐ Anxiety/Depression
☐ ☐ Fatigue
☐ ☐ Nausea
☐ ☐ Stress
☐ ☐ High/low blood pressure

C / P
☐ ☐ Vulvar varicosities
☐ ☐ Hemorrhoids
☐ ☐ Neck pain
☐ ☐ Upper back pain
☐ ☐ Mid back pain
☐ ☐ Low back pain
☐ ☐ Pelvic pain

C / P
☐ ☐ Other pain:
____
____
____
☐ ☐ Cramping/bleeding
☐ ☐ Breech

General Symptoms

C / P
☐ ☐ Poor appetite
☐ ☐ Large appetite
☐ ☐ Strongly like cold drinks
☐ ☐ Strongly like hot drinks
☐ ☐ Peculiar taste
☐ ☐ Cravings
☐ ☐ Sweats easily
☐ ☐ Night sweats
☐ ☐ Prolapsed organs

C / P
☐ ☐ Poor Sleep
☐ ☐ Dream disturbed sleep
☐ ☐ Heavy sleep
☐ ☐ Bodily heaviness
☐ ☐ Chills
☐ ☐ Fever
☐ ☐ Bleed or bruise easily
☐ ☐ Cold hands or feet

C / P
☐ ☐ Poor circulation
☐ ☐ Vertigo or dizziness
☐ ☐ Fatigue
☐ ☐ Lack of strength
☐ ☐ Shortness of breath
☐ ☐ Muscle cramps
☐ ☐ Anemic
☐ ☐ History of Cancer
What type: ______________ When: ______

Endocrine and Metabolic Disorders

☐ ☐ Hypothyroidism
☐ ☐ Adrenal burnout / fatigue
☐ ☐ Sweats easily

☐ ☐ Hyperthyroidism
☐ ☐ Diabetes Mellitus
☐ ☐ Weight gain

☐ ☐ Hypoglycemia
☐ ☐ Night sweats
☐ ☐ Weight loss

Head, Eyes, Ears, Nose, Throat

☐ ☐ Headaches
☐ ☐ Migraines
☐ ☐ Facial pain
☐ ☐ Glasses or Contacts
☐ ☐ Poor vision
☐ ☐ Blurred vision
☐ ☐ Eye strain
☐ ☐ Red eyes
☐ ☐ Itchy eyes
☐ ☐ Spots or floaters in eyes

☐ ☐ Glaucoma
☐ ☐ Night blindness
☐ ☐ Sores on lips or tongue
☐ ☐ Swollen glands
☐ ☐ Dry mouth
☐ ☐ Excessive saliva
☐ ☐ Recurrent sore throat
☐ ☐ Lumps in throat
☐ ☐ TMJ problems
☐ ☐ Teeth problems

☐ ☐ Grinding teeth
☐ ☐ Sinus problems
☐ ☐ Enlarged thyroid
☐ ☐ Excessive phlegm
☐ ☐ Ear aches
☐ ☐ Ringing in ears
☐ ☐ Poor hearing
☐ ☐ Gum problems
☐ ☐ Eye pain
☐ ☐ Concussions

Respiratory

☐ ☐ Difficulty breathing when lying down
☐ ☐ Shortness of breath
☐ ☐ Tight chest
☐ ☐ Cough   Wet or dry (circle one)

☐ ☐ Color of phlegm
____
☐ ☐ Coughing blood
☐ ☐ Asthma / Wheezing

☐ ☐ Pneumonia
☐ ☐ Frequent colds
☐ ☐ Persistent cough

Cardiovascular

☐ ☐ High blood pressure
☐ ☐ Tight chest
☐ ☐ Chest pain
☐ ☐ Pace maker

☐ ☐ Fainting
☐ ☐ Difficulty breathing
☐ ☐ Heart palpitations
☐ ☐ Low blood pressure

☐ ☐ Irregular heart beat
☐ ☐ Heart disease
☐ ☐ Blood clots

Are you currently taking Coumadin, Warfarin or any other blood thinners? ☐ Yes ☐ No

Genito-Urinary

☐ ☐ Pain when urinating
☐ ☐ Blood in urine
☐ ☐ Venereal disease
☐ ☐ Increased libido
☐ ☐ Urgency to urinate

☐ ☐ Frequent urination
☐ ☐ Bed wetting
☐ ☐ Unable to hold urine
☐ ☐ Decreased libido
☐ ☐ Difficulty urinating

☐ ☐ Wake to urinate
☐ ☐ Incomplete urination
☐ ☐ Kidney stone
☐ ☐ Incontinence

Urinary output equal to liquid intake? ☐ Yes ☐ No

Gastrointestinal

C / P
Bowel movements:
Frequency: ___________________________
Texture/Form: ________________________
Color: ______________________________
Odor: ______________________________
□ □ Diarrhea
□ □ Constipation
□ □ Laxative use
□ □ Mucous in stool
□ □ Undigested food in stool

C / P
□ □ Itchy anus
□ □ Anal fissures
□ □ Black stools
□ □ Bloody stools
□ □ Gas
□ □ Bloating
□ □ Intestinal pain or cramping
□ □ Burning anus
□ □ Rectal pain
□ □ Fatigue after eating

C / P
□ □ Hemorrhoids
□ □ Nausea
□ □ Vomiting
□ □ Acid regurgitation / Heart burn
□ □ Bad breath
□ □ Frequent hiccups
□ □ Gallbladder disease
□ □ Liver disease
□ □ Incomplete bowel movement

Skin and Hair

□ □ Rashes
□ □ Eczema
□ □ Dandruff
□ □ Hair loss
□ □ Change in hair / skin texture
□ □ Hives
□ □ Psoriasis
□ □ Itching
□ □ Fungal infections
□ □ Ulcerations
□ □ Acne

Neuropsychological

□ □ Seizures
□ □ Poor Memory
□ □ Irritability
□ □ Stroke
□ □ Mental tension
□ □ Considered or attempted suicide
When: ____________________
□ □ Numbness
□ □ Depression
□ □ Easily stressed
□ □ Mood swings
□ □ Anger easily
□ □ Tics
□ □ Anxiety
□ □ Abuse survivor
□ □ Mental fogginess
□ □ Loss of balance
□ □ Paralysis

Musculoskeletal pain

Please fill out the Pain Management Intake.

Your diet

Appetite: □ Low □ Strong □ Too busy to notice
□ □ Coffee (#/day) __________
□ □ Soft drinks (#/day) __________
□ □ Water (#/day) __________
□ □ Frequent thirst
□ □ Artificial sweeteners
□ □ Red meat
How frequently: ____________________
□ □ Decreased thirst
□ □ Energy Drinks
□ □ Dairy
How frequently: ____________________

Yesterday's breakfast: ______________________________ Lunch: ______________________________
Dinner: ______________________________ Snacks: ____________________ Is this a typical day? □ Yes □ No

Your lifestyle

□ □ Alcohol
How often? ________________
□ □ Marijuana
How often? ____________________
□ □ Tobacco
How much? ____________________
□ □ Occupational hazards
□ □ Other recreational drug use
□ □ Exercise Type: ______________________________ Frequency: ____________________
□ □ Stress Cause: ______________________________
Occupation: ______________________________ Hours/week: __________ Do you enjoy your job? □ Yes □ No

Your sleep

□ □ Difficulty falling asleep
□ □ Vivid dreams
□ □ Frequent waking What time: ____________________ For how long: ____________________
□ □ Difficulty staying asleep
□ □ Good sleep quality
□ □ Wake feeling rested
□ □ Poor sleep quality

Menstrual History

Age menses began: _________
Age menopause began: _________
Date of last menstrual period: __________
Are you pregnant, or is there a chance you are pregnant? □ Yes □ No
If yes, how many weeks? ________
Are your periods painful? □ Yes □ No
If so, how many days does the pain last? ________
What is the quality of pain? □ Sharp □ Dull □ Burning □ Cramping □ Fixed □ Moving
How many days do you typically bleed? _________
How heavy is the bleeding? □ Light □ Moderate □ Heavy
What day is the heaviest? _________
What color is the blood? □ Light red □ Red □ Dark red □ Brown □ Black
Is there clotting? □ Yes □ No if yes, what size: _________________
Average number of days in your cycle? _____________
Do you bleed or spot between periods? □ Yes □ No
Do you have premenstrual tension? □ Yes □ No
Does your face break out before your period? □ Yes □ No
Does your face break out during your period? □ Yes □ No
Do you have premenstrual breast tenderness? □ Yes □ No
Do you retain water during your period? □ Yes □ No
Do you get premenstrual low back pain? □ Yes □ No
Do you have loose bowel movements at the beginning of your period? □ Yes □ No
Have your cycles changed since they began? □ Yes □ No
If yes, describe:____
____
Do you ovulate on your own? □ Yes □ No
On what day of your cycle? ___________________
Do your breasts get tender at/during ovulation? □ Yes □ No
Date of last pap smear: ________________________
Have you ever had an abnormal pap smear? □ Yes □ No

Number & years:
Pregnancies: _______________________________________
Children: ____
Abortions: ____
Miscarriages: ______________________________________
D&C or D&E: ______________________________________
Complications: _____________________________________
____

Do you get yeast infections regularly? □ Yes □ No
Have you ever had a venereal disease? □ Yes □ No
Have you ever been diagnosed with Chlamydia? □ Yes □ No
Do you have chronic vaginal discharge? □ Yes □ No
If yes, what color?____________________
Does it have a smell? □ Yes □ No
If yes, what does it smell like? ______________________
Have you ever had pelvic inflammatory disease? □ Yes □ No
If yes, were you treated for it? □ Yes □ No
Treatment method: __________________________________
____
Have you ever been diagnosed with uterine fibroids or polyps? □ Yes □ No
Have you ever been diagnosed with endometriosis? □ Yes □ No
Have you been diagnosed with pelvic adhesions or abnormalities? □ Yes □ No
Have you been diagnosed with PCOS (Poly Cystic Ovary Syndrome)? □ Yes □ No
Have you taken any medications other than contraceptives for gynecological conditions? □ Yes □ No

Medication	Reason	How long?

Is there anything else about you or your health history you feel we should know about? ____
____
____
____