

# Acupuncture 5 Phase Intake

## Wood Phase

	<u>Always</u>	<u>Sometimes</u>	<u>Never</u>
<b>Headaches</b>			
Migraines	<input type="checkbox"/>		<input type="checkbox"/>
One-sided	<input type="checkbox"/>		<input type="checkbox"/>
Around the eyes	<input type="checkbox"/>		<input type="checkbox"/>
Neck & Shoulders	<input type="checkbox"/>		<input type="checkbox"/>
Hatband distribution	<input type="checkbox"/>		<input type="checkbox"/>
Back of head	<input type="checkbox"/>		<input type="checkbox"/>
Inside head	<input type="checkbox"/>		<input type="checkbox"/>
Top of head	<input type="checkbox"/>		<input type="checkbox"/>
Better with heat	<input type="checkbox"/>		<input type="checkbox"/>
Better with cold	<input type="checkbox"/>		<input type="checkbox"/>
Worse with light	<input type="checkbox"/>		<input type="checkbox"/>
Worse with period	<input type="checkbox"/>		<input type="checkbox"/>
Worse in morning	<input type="checkbox"/>		<input type="checkbox"/>
Worse in afternoon	<input type="checkbox"/>		<input type="checkbox"/>
Worse at night	<input type="checkbox"/>		<input type="checkbox"/>
Better after eating	<input type="checkbox"/>		<input type="checkbox"/>
Duration of HA	_____mins/hrs/days		
Frequency	Hourly/Daily/Weekly		

### **Do you drink...**

Coffee	<input type="checkbox"/>		<input type="checkbox"/>
Alcohol	<input type="checkbox"/>		<input type="checkbox"/>
Soda	<input type="checkbox"/>		<input type="checkbox"/>
Iced drinks	<input type="checkbox"/>		<input type="checkbox"/>

	<u>Always</u>	<u>Sometimes</u>	<u>Never</u>
<b>Eyes</b>			
Dry eyes	<input type="checkbox"/>		<input type="checkbox"/>
Red eyes	<input type="checkbox"/>		<input type="checkbox"/>
Itchy eyes	<input type="checkbox"/>		<input type="checkbox"/>
Painful eyes	<input type="checkbox"/>		<input type="checkbox"/>
Spots in front of eyes	<input type="checkbox"/>		<input type="checkbox"/>
Contacts/glasses	<input type="checkbox"/>		<input type="checkbox"/>
Poor night vision	<input type="checkbox"/>		<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>		<input type="checkbox"/>
Colorblind	<input type="checkbox"/>		<input type="checkbox"/>
Don't like bright colors	<input type="checkbox"/>		<input type="checkbox"/>

### **Emotional Considerations**

Depression	<input type="checkbox"/>		<input type="checkbox"/>
Impatient	<input type="checkbox"/>		<input type="checkbox"/>
Can't control temper	<input type="checkbox"/>		<input type="checkbox"/>
Under Stress	<input type="checkbox"/>		<input type="checkbox"/>
Good ability to plan	<input type="checkbox"/>		<input type="checkbox"/>
Feeling of lump In the throat	<input type="checkbox"/>		<input type="checkbox"/>
Hard to make decisions	<input type="checkbox"/>		<input type="checkbox"/>
Feeling frustrated	<input type="checkbox"/>		<input type="checkbox"/>

**Gynecological**

	<u>Always</u>	<u>Sometimes</u>	<u>Never</u>
No period for >4 mnth	<input type="checkbox"/>		<input type="checkbox"/>
Delayed menstration	<input type="checkbox"/>		<input type="checkbox"/>
Irregular menstration	<input type="checkbox"/>		<input type="checkbox"/>
Painful menstration	<input type="checkbox"/>		<input type="checkbox"/>
Severe cramps	<input type="checkbox"/>		<input type="checkbox"/>
Dull/diffuse pain	<input type="checkbox"/>		<input type="checkbox"/>
Stabbing/sharp pain	<input type="checkbox"/>		<input type="checkbox"/>
Pain improved w/ heat	<input type="checkbox"/>		<input type="checkbox"/>
Clots	<input type="checkbox"/>		<input type="checkbox"/>
Copious flow	<input type="checkbox"/>		<input type="checkbox"/>
Scant flow	<input type="checkbox"/>		<input type="checkbox"/>
Bright red flow	<input type="checkbox"/>		<input type="checkbox"/>
Dark red flow	<input type="checkbox"/>		<input type="checkbox"/>
Duration of cycle			
Duration of menses			
Moody before period	<input type="checkbox"/>		<input type="checkbox"/>
Mood improves during Menses	<input type="checkbox"/>		<input type="checkbox"/>
Indigestion w/ period	<input type="checkbox"/>		<input type="checkbox"/>
Back pain w/ period	<input type="checkbox"/>		<input type="checkbox"/>
Acne w/ period	<input type="checkbox"/>		<input type="checkbox"/>
Breast distention	<input type="checkbox"/>		<input type="checkbox"/>
Abdominal bloating	<input type="checkbox"/>		<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>		<input type="checkbox"/>
Night sweats	<input type="checkbox"/>		<input type="checkbox"/>
New breast lumps	<input type="checkbox"/>		<input type="checkbox"/>
Discharge from nipples	<input type="checkbox"/>		<input type="checkbox"/>
Yeast infections	<input type="checkbox"/>		<input type="checkbox"/>

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Vaginal Discharge	<input type="checkbox"/>		<input type="checkbox"/>
clear	<input type="checkbox"/>		<input type="checkbox"/>
white/milky	<input type="checkbox"/>		<input type="checkbox"/>
yellow	<input type="checkbox"/>		<input type="checkbox"/>
red	<input type="checkbox"/>		<input type="checkbox"/>
green	<input type="checkbox"/>		<input type="checkbox"/>
Age of first menses			
Age menopause began			
# of pregnancies			
# of miscarriages			
# of births			
# of premature births			
Last Pap smear			
Day last period began			

**Neuro-musculo Problems**

Tight neck/shoulders	<input type="checkbox"/>		<input type="checkbox"/>
Tight sides of legs	<input type="checkbox"/>		<input type="checkbox"/>
Sciatica	<input type="checkbox"/>		<input type="checkbox"/>
Convulsions	<input type="checkbox"/>		<input type="checkbox"/>
Twitches or tics	<input type="checkbox"/>		<input type="checkbox"/>
Tremors	<input type="checkbox"/>		<input type="checkbox"/>
Ringin in the ears	<input type="checkbox"/>		<input type="checkbox"/>
Vertigo	<input type="checkbox"/>		<input type="checkbox"/>

**Other Conditions/History**

Gall Bladder Removed	Yes	____	No
Hepatitis	Yes	____	No
Chirrosis	Yes	____	No
Gall Stones	Yes	____	No
Hysterectomy	Yes	____	No
Ovarian surgery	Yes	____	No

# Fire Phase

Always Sometimes Never

## General

- Fatigue/Listlessness  \_\_\_\_\_
- Difficulty breathing on Exertion  \_\_\_\_\_
- Sweating  \_\_\_\_\_
- Feeling of discomfort in Chest or in the heart  \_\_\_\_\_
- Cold Hands  \_\_\_\_\_
- Feeling cold and Aversion to cold  \_\_\_\_\_
- Burning urine  \_\_\_\_\_
- Urinary tract infection  \_\_\_\_\_
- Dizziness  \_\_\_\_\_

## Insomnia

- Can't get to sleep at night  \_\_\_\_\_
- Read in bed for a long time  \_\_\_\_\_
- Wake up at night  \_\_\_\_\_
- Wake up in early morning  \_\_\_\_\_
- Can't get back to sleep  \_\_\_\_\_
- Disturbing dreams  \_\_\_\_\_
- Last meal after 7:00 PM  \_\_\_\_\_

## Palpitations

- Heart seems to beat faster  \_\_\_\_\_
- Heart beats irregularly: Evening/daytime/exertion  \_\_\_\_\_

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## Emotional Considerations

- Stutters  \_\_\_\_\_
- Anxiety  \_\_\_\_\_
- Easily startled or fidgety  \_\_\_\_\_
- Recent emotional shock  \_\_\_\_\_
- Uncontrollable laughter  \_\_\_\_\_
- Manic/depressive  \_\_\_\_\_
- Recent excitements  \_\_\_\_\_
- Poor memory  \_\_\_\_\_
- "Dull" thinking  \_\_\_\_\_

## General Family Health

- Heart attacks Yes \_\_\_\_\_ No
- High blood pressure Yes \_\_\_\_\_ No
- Diabetes Yes \_\_\_\_\_ No
- Arthritis Yes \_\_\_\_\_ No
- Cancer Yes \_\_\_\_\_ No

# Earth Phase

Always Sometimes Never

## General

- |                              |                          |       |                          |
|------------------------------|--------------------------|-------|--------------------------|
| Weakness of limbs            | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Stiffness in epigastric area | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Prolapse of stomach, uterus  | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Hemorrhoids                  | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| White vaginal discharge      | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Frequent urination           | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Low grade fever during day   | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Blood in urine or stool      | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Blood spots under skin       | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Bruise easily/varicosities   | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Gum disease                  | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Toothache                    | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Cankersores/Cold sores       | <input type="checkbox"/> | _____ | <input type="checkbox"/> |

## Digestive

- |   |                          |       |                          |
|---|--------------------------|-------|--------------------------|
| ↑↑ or ↓↓ Appetite                         | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Abdominal distension                      | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Loose stool/diarrhea                      | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Hard stool/constipation                   | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Cold stomach area<br>(relieved by warmth) | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| “Heavy joints”                            | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Edema                                     | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Cold limbs                                | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Nausea                                    | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Acid regurgitation/vomiting               | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Belching/Gas/Bad breath                   | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Hiccups                                   | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Sweet taste in mouth                      | <input type="checkbox"/> | _____ | <input type="checkbox"/> |

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## Dietary Habits

- |                             |                          |       |                          |
|-----------------------------|--------------------------|-------|--------------------------|
| Eat at irregular times      | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Do business while eating    | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Eat cold/raw foods          | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Drink cold fluids           | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Drink a lot of fluids       | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Drink liquids in small sips | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| No thirst                   | <input type="checkbox"/> | _____ | <input type="checkbox"/> |

## Emotional Considerations

- |                          |                          |       |                          |
|--------------------------|--------------------------|-------|--------------------------|
| Studying/mental work     | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Brooding                 | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Overly caring for others | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Mothering type of person | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Feeling insecure         | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Feeling “spacey”         | <input type="checkbox"/> | _____ | <input type="checkbox"/> |

# Metal Phase

## General

	<u>Always</u>	<u>Sometimes</u>	<u>Never</u>
Tiredness	<input type="checkbox"/>	_____	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	_____	<input type="checkbox"/>
Asthma/emphysema	<input type="checkbox"/>	_____	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	_____	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	_____	<input type="checkbox"/>
Soft voice	<input type="checkbox"/>	_____	<input type="checkbox"/>
Difficult breathing while Lying down	<input type="checkbox"/>	_____	<input type="checkbox"/>
Barking or dry cough	<input type="checkbox"/>	_____	<input type="checkbox"/>
Sputum/phlegm	<input type="checkbox"/>	_____	<input type="checkbox"/>
Clear/watery/white	<input type="checkbox"/>	_____	<input type="checkbox"/>
Yellow	<input type="checkbox"/>	_____	<input type="checkbox"/>
Green	<input type="checkbox"/>	_____	<input type="checkbox"/>
Blood tinged	<input type="checkbox"/>	_____	<input type="checkbox"/>
Bad smelling	<input type="checkbox"/>	_____	<input type="checkbox"/>
Chronic bronchitis/colds	<input type="checkbox"/>	_____	<input type="checkbox"/>
Sore/itchy throat	<input type="checkbox"/>	_____	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	_____	<input type="checkbox"/>
Fever	<input type="checkbox"/>	_____	<input type="checkbox"/>
Prone to sweating	<input type="checkbox"/>	_____	<input type="checkbox"/>
Sweats profusely	<input type="checkbox"/>	_____	<input type="checkbox"/>

## Skin Problems

	<u>Always</u>	<u>Sometimes</u>	<u>Never</u>
Swelling of eyes/face	<input type="checkbox"/>	_____	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	_____	<input type="checkbox"/>
Hives	<input type="checkbox"/>	_____	<input type="checkbox"/>
Boils	<input type="checkbox"/>	_____	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	_____	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	_____	<input type="checkbox"/>
Dry/itchy skin	<input type="checkbox"/>	_____	<input type="checkbox"/>
White patches	<input type="checkbox"/>	_____	<input type="checkbox"/>

## Emotional Considerations

Sadness/loss of loved one	<input type="checkbox"/>	_____	<input type="checkbox"/>
Emotional breakup grief	<input type="checkbox"/>	_____	<input type="checkbox"/>
Not letting go of emotion	<input type="checkbox"/>	_____	<input type="checkbox"/>
Smoker	<input type="checkbox"/>	_____	<input type="checkbox"/>

# Water Phase

Always Sometimes Never

## General

- Chronic illness  \_\_\_\_\_
- Slow onset of tinnitus  \_\_\_\_\_
- Dry mouth at night  \_\_\_\_\_
- Hearing loss  \_\_\_\_\_
- General feeling of cold  \_\_\_\_\_
- Night sweats  \_\_\_\_\_
- Sweating of the hands, feet  
And at the sternum  \_\_\_\_\_
- Premature graying or  
Loss of hair  \_\_\_\_\_
- Low or increased sex drive  \_\_\_\_\_

## Congenital Anomalies

- Poor bone formation  \_\_\_\_\_
- Slow growth  \_\_\_\_\_
- Dental problems  \_\_\_\_\_
- Loose teeth  \_\_\_\_\_
- Weak/soft/broken bones  \_\_\_\_\_

## Neuro-musculo Problems

- Weak or cold knees  \_\_\_\_\_
- Low back or spinal pain  \_\_\_\_\_
- Chondromalacia Patella  \_\_\_\_\_
- Edema in the legs  \_\_\_\_\_

Always Sometimes Never

## Genito-Urinary Problems

- Scanty urination  \_\_\_\_\_
- Clear urination  \_\_\_\_\_
- Weak stream urination  \_\_\_\_\_
- Dribbling urination  \_\_\_\_\_
- Abundant urination  \_\_\_\_\_
- Urinary incontanance  \_\_\_\_\_
- Frequent urination  \_\_\_\_\_
- Kidney pain or stones  \_\_\_\_\_
- Bladder infections  \_\_\_\_\_
- Nocturnal emissions  
w/ dreams  \_\_\_\_\_
- w/o dreams  \_\_\_\_\_
- Impotence/infertility  \_\_\_\_\_
- Premature ejaculation  \_\_\_\_\_
- Prostate problems  \_\_\_\_\_
- Chronic vaginal discharge  \_\_\_\_\_
- Prolapse of uterus  \_\_\_\_\_

## Emotional Considerations

- Fearful  \_\_\_\_\_
- Insecure about work/life  \_\_\_\_\_
- Difficult to undertake new  
projects  \_\_\_\_\_
- Determined  \_\_\_\_\_
- Lack of will power  \_\_\_\_\_

What would you like to achieve with your acupuncture treatments?

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Are there any specific health concerns that you would like addressed?

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\_\_\_\_\_  
Initial

\_\_\_\_\_  
Date