

PATIENT INTAKE FORM

DATE _____

PLEASE FILL OUT AS COMPLETE AS POSSIBLE. THIS INFORMATION IS VERY IMPORTANT FOR YOUR TREATMENT

Name _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____

Marital Status: M S D W Home Phone _____ Work Phone _____ Ext _____

Social Security # _____ Driver License # _____ REFERRED BY _____

Blood Type O A B AB Emergency Name and Phone#: _____

Occupation _____ Employer _____ # Years _____

Work Address _____ City _____ State _____ Zip _____

Date of last physical or exam _____ Height _____ Weight _____ Blood Pressure _____

Circle the following conditions that apply to you: Alcoholism, Anemia, Appendicitis, Allergies, Arthritis, Asthma, Arteriosclerosis, Birth Trauma (your own birth) Chronic Sinus infections, Cancer, Crohn's Disease, Chicken Pox, Diabetes, Eczema, Emphysema, Epilepsy, Goiter, Gout, Hepatitis (A B C), Heart Disease, HIV, Hypertension, Mental Illness, Multiple sclerosis, Malaria, Mumps, Measles, Osteoporosis, Pacemaker, Parasites, Pleurisy, Pneumonia, Polio, Rheumatic Fever, Scarlet Fever, Seizures, Severe Acne, Stroke, Tuberculosis, Venereal Disease, Whooping Cough. Other _____

Have any of you blood relatives had any of the above? Please write all that apply _____

What vaccinations have you had and what effects did they have on your health, if any? _____

History of Antibiotic treatment? _____

Please list all diseases and injuries you have had and any treatment (medication, hospitalizations) related to them, including the dates and whether you feel you fully recovered from them _____

List any scars and locations _____

Have you had acupuncture before? Yes No Chinese Herbal medicine? Yes No
Are you under the care of a physician now? Yes No If yes, what for? _____
Physicians name? _____ Physicians Phone _____
Other concurrent therapies at this time: _____

MAIN COMPLAINT(S) _____

Date of Illness or Injury _____ How did it occur? _____
Pain or Illness is: Minimal Slight Moderate Severe Other: _____
How long have you had this condition(s)? _____
Have you had this in the past? Yes No When? _____
Is your condition: Getting worse Constant Comes and goes Other: _____
What makes it better? _____
What makes it worse? _____

OTHER COMPLAINTS: _____

Medication and Supplements taken within the last 6 months including prescriptions, over-the-counter
drugs, herbs, vitamin/minerals, laxatives, etc: _____

ENERGY LEVEL: High (time of day) _____ Low (time of day) _____ Related to: food, coffee, tea
Other: _____

PHYSICAL STRESS: None Moderate Severe What makes it better or worse? _____

EMOTIONAL STRESS: None Moderate Severe Describe: _____

WHAT IS YOUR FAVORITE: Time of day _____ Time of year _____
Color _____ Environment _____ Exercise _____

LEAST FAVORITE: Time of day _____ Time of year _____
Color _____ Environment _____ Exercise _____

PLEASE CIRCLE ALL THAT APPLY

SWEATING: Night sweats Rarely sweat Excess sweating Odor Hands Feet Other: _____

CIRCULATION: Poor Good Hot Cold What area? _____ Bleed easily

SLEEP: Restful Restless Not rested when you wake up How many hours do you sleep a night _____
Is that enough? Yes No. Trouble falling asleep Active mind Worry Fear Other _____
Trouble staying asleep. Dreams: Good Bad Often Rarely Recurring General themes? _____

BOWELS: Painful Diarrhea Constipation Bloody Black Mucus Hemorrhoids Gas Foul odor
Colitis. # of bowel movements a day _____ Other _____

URINE: General color _____ Infrequent Frequent Retention Pain Burning Strong odor Cloudy
Dribbling Blood Frequent infections Retention Urge to go but can't. # times per Day ___ Night ___
Other _____

SKIN: Dry Itchy Moist/clammy Burning Changing Moles or Lumps (cysts/tumors) Boils Rashes
Acne Hair loss/thinning Dry scalp Skin puffy/wrinkled Bruises easily Hives Other: _____

HEAD: Headaches What areas: _____ When do they occur _____
Dizziness Memory loss Loss of balance Fainted Other: _____

EYES: Pain Dry Red Discharges Blurred vision Darkness under eyes Watery Nearsighted Farsighted
Other _____

EARS: Poor hearing Earaches Discharges/infections Ringing/buzzing Other _____

NOSE: Frequent nosebleeds Sinus trouble Frequent colds Runny Dry Itchy Sores Sneezing
Other _____

THROAT: Sore Hoarseness Difficulty swallowing Teeth/gum problems Swollen tongue
Jaw problems Teeth sensitive to cold/hot Other _____

CHEST: Pain/Pressure Hard to breath at times Wheezing Mucus rattles when breathing Palpitations
Shortness of breath Trouble breathing at night. Cough: Chronic, Persistent, Dry, Wet, Blood,
Spasmodic, Sputum color _____ Consistency: Thick Thin Watery Other _____

MUSCULOSKELETAL: Pain/discomfort in: Neck Shoulder Between shoulders Arms/hand Hip
Knee Ankles Fingers Toe's Upper back Mid back Lower back Bones. Swollen knees/elbows
Loss of grip Leg cramps at night Weakness in legs Weak ankles Stiff joints Tingling in feet
Muscle spasm/cramps Loss of feeling in hands/feet Bursitis
Generally better and worse from _____

NEUROLOGICAL: Tremors Seizures Numbness/tingling in _____ Poor coordination Shingles
Muscle weakness Feel weak and shaky Neuralgia (nerve pain) in _____
Other _____

FEMALE: Date of last period _____ Last PAP test _____ Days between cycle _____ Days of flow _____
Form of birth control: None Pill Other _____ If yes, is it to: Regulate period Birth control? _____
Age started period _____ Stopped _____ Do you have: Menstrual/cramping or pain Low backache
Clotting Heavy bleeding Light scanty bleeding Water retention Mood changes Cravings Painful
breast Hot flashes Skip periods Low or no sex drive.
Color of blood throughout period _____
Discharges: Yellow White Clear Thick Scanty Copious Odors Itching Other _____

Pregnancies ___ # Deliveries ___ # Miscarriages ___ # Abortions ___ # Cesareans ___

GYN Operations: _____

MALE: Low or lack of sexual drive Impotence Premature ejaculation Ejaculation causes pain
Discharges Prostate problems Pain or burning while urinating Other _____

APPETITE: Excessive Poor Changing Feel tired/weak if a meal is missed Eat quickly Never thirsty
Excessive thirst Eat when nervous or working Never satisfied Eat frequently Eat late in evening
Prefer: Sweet, Spicy, Salty, Sour, Bitter, Bland, Fried, Raw, Well Cooked Other _____
Specific foods you crave or dislike _____
Food allergies or sensitivities _____

DIGESTION: Stomach discomfort Gas Heartburn Burping/Belching Pain Cramps Nausea Vomiting
Bad breath Sores in mouth Taste in mouth: Bitter, Sour, Salty, Bland, Other _____
Weight gain Weight loss Bloating How long after eating? _____ Other _____

EATING HABITS: How many meals a day do you eat _____ When is you biggest meal _____
How many glasses of water do you drink a day _____ Is it Tap Filtered Bottled Other _____

DO YOU: Eat when you are worried or rushed: Yes No If yes how often _____
Use Alcohol: Yes No Amount per day/week _____ Tobacco Packs per day _____ How many years _____
Eat or drink dairy products every day Eat until you feel full Eat frequently between meals
Eat late in the evening or have late night snacks Eat the same foods almost every day
Eat protein at least one time a day Eat green or yellow vegetables at least: Once Twice a day
Chew your food thoroughly before swallowing Go on "diets" often
Eat or drink cold beverages or food often: Yes No
Eat out often How many times a day, and what meal (s) _____ Week _____
Drink fluids with or directly after your meal Yes No How much _____ What kind _____
Eat at regular intervals (i.e. 7am 1pm 6pm) Yes No If no, when do you normally eat _____
Give a typical Breakfast, Lunch, Dinner and Daily Snacks _____

Circle all statements that are true about yourself, I am.... or I....

Usually calm Easily irritated Stubborn Tend to contradict Find fault in others Tend to be in a hurry
Lack of self-confidence Often anxious Worry about the future Worry about my health Sentimental
Weep easily even without cause Can become emotional (easily or rarely) Are suspicious of others
Feel (better or worse) when consoled Feel worse in the company of others Often jealous Clumsy
Overly sensitive Hard working Lazy Easily frightened or fearful Tend to be moody Talkative
Fastidious (meticulous) Have a poor memory Have nervous habits as nail biting or _____
Often absent minded Prefer to be alone Have thoughts of committing suicide
Lack courage to commit suicide Family is (very or not) important to me.

Bruce Pendleberry, OMD, LAc, DHM

Phone: 805-496-7723

Oriental Medicine Homeopathic Medicine Naturopathic Medicine

Everyone in our office joins me in welcoming you into our health care practice. Please read this carefully to acquaint yourself with my services and policies.

My Services Include

Acupuncture with needles, micro-current, laser, magnets and press needles
Chinese Herbal Medicine
BioEnergetic Evaluation through Biokinesiology
Homeopathy
Dietary and Lifestyle Analysis
AcuGraph Electrical Point and Channel Analysis
Nutritional Therapy

Office Hours

Day	Morning Hours	Afternoon Hours	Last Appt times A.M. & P.M.
Monday	8:30 am - 1 pm	2 pm - 5 pm	12:30 am 5:00 pm
Tuesday	8:30 am - 1 pm	2 pm – 4:30 pm	12:30 am 4:30 pm
Wednesday	8:30 am - 1 pm	2 pm - 5 pm	12:30 am 5:00 pm
Thursday	Closed	Closed	
Friday	8:30 am - 1 pm	2 pm - 5 pm	12:30 am 5:00 pm
Saturday	Closed	Closed	

Be sure to maintain your appointment schedule. If you must cancel, we request 24 hours notice so that another person may take that time. This is very important because we are usually booked the whole day and have people waiting for an opening.

Please do your best to be on time. If one person is late it can affect my schedule and all the other patients for the rest of the morning or afternoon. I will do my best to get you in quickly and give you my full attention for your appointment time. This is very important so that I can give you the best care possible.

Financial Polices:

If you have insurance that covers acupuncture by an acupuncturist we will print out a superbill for you to submit to your insurance company.

Please note that supplies and supplements are not covered by you insurance and must be paid for when received.

VISA, Master Card, Discover, and American Express are welcome.

Financial arrangements made upon request.

Recommendations To Enhance Your Treatment

Please arrive promptly without being rushed. Avoid coffee, alcohol and other stimulants for 4 hours before treatments, if possible. Do not arrive very hungry. Schedule your exercise program so that your exercise for that day is done before Acupuncture, not afterwards (only if you are receiving Acupuncture). Keep your appointments as a commitment to your recovery and good health.

If you are taking many different supplements bring them in so I can go over them with you.

Patient Signature: _____ Date: _____

FROM LOS ANGELES

Take the US-101 VENTURA FWY NORTH.

Take the WESTLAKE BLVD exit.

Turn RIGHT onto S WESTLAKE BLVD, Heading towards THOUSAND OAKS BLVD. Approx 0.19 miles

Turn LEFT onto E THOUSAND OAKS BLVD. then drive approx 0.57 miles

Turn RIGHT onto AUBURN CT, we are behind KFC on RT side. The HEATHERLY BUILDING.

Enter through the back of building through the double doors, 1st door on RT.

FROM VENTURA

Take the US-101 VENTURA FWY SOUTH.

Take the HAMPSHIRE RD exit.

Turn LEFT onto HAMPSHIRE RD. Drive approx 0.28 miles

Turn RIGHT onto E THOUSAND OAKS BLVD. Drive approx 0.40 miles passing the Post Office on LT

Turn LEFT onto AUBURN CT, we are behind KFC on RT side. The HEATHERLY BUILDING.

Enter through the back of building through the double doors, 1st door on RT.



