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Acupuncture Intake Form

all information will remain confidential

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible and indicate areas of confusion with a question mark. Thank you!

PATIENT CONTACT INFORMATION:

Date: ___/___/_____

Name: _____ Age: _____ Birthdate: ___/___/___ Gender:

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone Number: _____ Please Circle: Home Work Cell

May we leave messages at this number? ☐ Yes ☐ No E-mail Address: _____

Occupation: _____ Company Name: _____

Primary Physician: *(If any)*: _____ Late Visit Date:_____ Physician Phone Number: _____

Person we may contact if needed: _____ Relationship: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

How did you hear about us? _____

HEALTH HISTORY:

What are your primary concerns for coming in for treatment?	List meds, vitamins or supplements you are taking:
1.	
2.	
3.	
How is your sleep?	
How is your digestion?	
Are you a vegetarian? ☐ Yes ☐ No	List serious illnesses, accidents or surgeries:
List any food, drugs or substances you are hypersensitive or allergic to:	

CHECK ILLNESSES THAT HAVE OCCURRED IN BLOOD RELATIVES:

☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Cancer
☐ Heart Disease ☐ Kidney Disease

CHECK SYMPTOMS YOU HAVE OR HAVE HAD IN THE LAST YEAR:

☐ Depression/anxiety ☐ Difficulty in focusing ☐ Dizziness ☐ Easily startled
☐ Excessive worry ☐ Excessive fear ☐ Fatigue/tiredness ☐ Mood swings
☐ Headaches, if so where?:_____ ☐ Loss of sleep or poor sleep
☐ Weight gain or loss ☐ Nervousness or irritability ☐ Overwhelmed by life

CHECK CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

☐ AIDS ☐ Allergies ☐ Anemia ☐ Arthritis
☐ Bleeding Disorders ☐ Breast Lump ☐ Cancer ☐ Diabetes
☐ Eczema ☐ Thyroid condition

CHECK SYMPTOMS YOU HAVE OR HAVE HAD IN THE LAST YEAR

Muscle/Joint/Bones				**Cardiovascular**		
	☐ Tremors or cramps	☐ Swollen joints			☐ Varicose veins	☐ Chest Pain
Pain, Weakness, Numbness in:					☐ High or low blood pressure	☐ Palpitations
	☐ Arms	☐ Back legs			☐ Previous heart attack	☐ Poor circulation
	☐ Feet	☐ Neck			☐ Rapid/irregular heart beat	☐ Swelling of ankles
	☐ Hands	☐ Shoulders			☐ Cold hands and feet	
	☐ Low back	☐ Hips		**Gastrointestinal**		
Eyes/Ear/Nose/Throat/Respiratory					☐ Belching, gas or bloating	☐ Colon Trouble
	☐ Blurred or failing vision	☐ Asthma/wheezing			☐ Constipation	☐ Diarrhea
	☐ Difficulty breathing	☐ Earache			☐ Difficulty swallowing	☐ Excessive hunger
	☐ Enlarged glands	☐ Eye pain			☐ Distention of abdomen	☐ Gallbladder trouble
	☐ Frequent colds	☐ Grinding teeth			☐ Hemorrhoids (piles)	☐ Indigestion
	☐ Gum/teeth trouble	☐ Hay fever			☐ Pain over stomach	☐ Nausea
	☐ Hoarseness	☐ Jaw pain			☐ Poor appetite	☐ Vomiting
	☐ Nose bleeds	☐ Loss of hearing		**Please Answer As Relevant**		
	☐ Persistent cough	☐ Ringing in the ears			☐ Erection difficulties	☐ Penile discharge
	☐ Sinus problems				☐ Pain or lumps in testicles	☐ Prostrate trouble
Skin					☐ Bleeding between periods	☐ Clots in menses
	☐ Boils	☐ Bruise easily			☐ Excessive menstrual flow	☐ Irregular cycle
	☐ Dry skin	☐ Feeling hot or cold			☐ Extreme menstrual pain	☐ Hysterectomy
	☐ Itching/rash	☐ Night Sweats			☐ Menopausal symptoms	☐ PMS
	☐ Sensitive skin	☐ Sores that won't heal			☐ Breast tenderness	☐ Vaginal discharge
Genito/Urinary					☐ Scanty menstrual flow	☐ Previous miscarriage
	☐ Blood/pus in urine	☐ Frequent urination			☐ Last PAP smear date: ___/____/_____	
	☐ Frequent UTI	☐ Inability to control urine			☐ Number of pregnancies: _____	
	☐ Kidney infection/stones	☐ Lowered libido			☐ Could you be pregnant?:	☐ Yes ☐ No

SIGNATURE / THE INFORMATION ON THIS FORM IS CORRECT AND TO THE BEST OF MY KNOWLEDGE

_____ Date: _____