Acupuncture Intake Form

Date: _____

First Name: _____ Middle Name: _____Last Name: _____

Date of Birth: _____ Age: _____ Gender: M / F Height: _____ Weight: _____

Address: _____ City/State: _____ Zip code: _____

Best ph. number for reminder calls: _____ Email address: _____

Your occupation: _____ Relationship status: _____ Number of children: _____

Emergency Contact: _____ Phone: _____ Relationship to you: _____

Primary Care Physician: _____ Date of last visit: _____ Reason for visit: _____

Are you pregnant? N / Y How many weeks?_____ How did you hear about me? _____

Please identify the primary health concerns that have caused you to seek treatment in order of importance:

Condition	When did it start?	How does this condition affect you?
1.		
2.		
3.		

Past or current treatments for the above and their outcomes:

_____

_____

List major illnesses, emotional trauma, accidents and surgeries, including dates if possible:

_____

_____

List current contagious diseases: _____

List all medications and supplements you are currently taking and dosages: (attach an extra sheet if necessary)

_____

_____

_____

List allergies/sensitivities and type of reaction:

_____

_____

_____

Have you received acupuncture treatment or Chinese herbs in the past? No / Yes When? _____

Family Medical History: Please identify immediate blood relatives who have experienced the following conditions	
□ Addiction (type):	□ Hay fever /hives:
□ Autoimmune disorder (type):	□ High Blood Pressure:
□ Asthma:	□ Kidney Disease:
□ Cancer (type):	□ Mental Illness :
□ Diabetes (type):	□ Obesity:
□ Heart Disease:	□ Stroke:

Lifestyle: Please check that which applies				
Work Activity:	Exercise:	Energy for Daily Tasks:	Typical Stress Level:	Habits:
□ Sitting	□ None	□ Low	□ Low	□ Smoke packs/day:
□ Standing	□ Moderate	□ Sufficient	□ Moderate	□ Alcohol drinks/wk:
□ Light Labor	□ Daily	□ Good	□ High	□ Caffeine cups/day:
□ Heavy Labor	□ Heavy	□ Hyper	□ Very High	□ Other:

How is your sleep? _____ How many hours/night? _____ Wake feeling rested? Y / N

Health Systems: Please check any symptoms you have experienced in the last 3 months:

GENERAL
□ Fatigue
□ Energy drop
Time: _____
□ Sweats easily
□ Heat or cold intolerance
□ Change in appetite
□ Change in thirst
□ Weight loss
□ Weight gain
_____lbs over ____months

SKIN & HAIR
□ Rash
□ Dry skin
□ Hives
□ Acne or pimples
□ Itching
□ Eczema
□ Psoriasis
□ Loss of hair
□ Dandruff
□ Sores

HEAD
□ Headaches
□ Migraines
□ Head injury

EYES
□ Impaired vision
□ Eye pain
□ Dry eyes
□ Excessive tearing
□ Double vision
□ Floaters
□ Glaucoma
□ Cataracts

NOSE & SINUS
□ Frequent colds
□ Nose bleeds
□ Nasal drainage
□ Stuffiness
□ Sinus Problems
□ Hay fever

EARS
□ Impaired hearing
□ Earaches
□ Discharge
□ Dizziness
□ Ringing

MOUTH & THROAT
□ Frequent sore throats
□ Dental cavities
□ Gum problems
□ Grinding teeth
□ Hoarseness
□ Swollen glands
□ Sores on lips or tongue

RESPIRATORY
□ Persistent cough
□ Asthma / wheezing
□ Pain on breathing
□ Shortness of breath
□ Phlegm / sputum
□ Bronchitis
□ Pneumonia
□ Tuberculosis
□ Emphysema

CARDIOVASCULAR
□ Heart disease
□ High blood pressure
□ Low blood pressure
□ Chest pain
□ Palpitations
□ Swelling in ankles/ hands
□ Cold hands/ feet
□ Anemia
□ Bruise easily
□ Bleed easily
□ Deep leg pain

GASTROINTESTINAL
□ Heartburn
□ Gas & bloating
□ Abdominal pain
□ Loose stools
□ Diarrhea
□ Constipation
□ Blood in stools
□ Hemorrhoids

URINARY
□ Pain on urination
□ Increased frequency
□ Frequency at night
□ Urgency to urinate
□ Inability to hold urine
□ Blood in urine
□ Frequent infections

NEUROLOGIC
□ Vertigo
□ Fainting
□ Seizures
□ Paralysis
□ Muscle weakness
□ Numbness/ tingling
□ Poor memory
□ Concentration problem
□ Poor balance

ENDOCRINE
□ Hypothyroid
□ Hypoglycemia
□ Hyperthyroid
□ Excessive thirst
□ Excessive hunger
□ Sugar cravings

EMOTIONAL
□ Depression
□ Anxiety
□ Mood swings
□ Bad temper
□ Easily susceptible to stress
□ Tendency to ruminate or over analyze
□ Addiction

MUSCULOSKELETAL
□ Joint pain &stiffness
□ Arthritis
□ Muscle pain
□ Muscle spasms
□ Muscle weakness
□ Neck pain
□ Shoulder pain
□ Elbow pain
□ Wrist pain
□ Upper back pain
□ Lower back pain
□ Hip pain
□ Knee pain
□ Foot / ankle pain
□ Broken bone

MALE REPRODUCTIVE
□ Hernias
□ Testicular mass
□ Testicular pain
□ Prostate disease
□ Sexual difficulties
□ Diminished sex drive
□ Difficulty conceiving
□ Erectile dysfunction
□ STDS
□ Discharge

FEMALE REPRODUCTIVE
Age menses began _____
Ave # of days _____
Length of cycle _____
Date last period began:
_____
□ Heavy periods
□ Light periods
□ Painful periods
□ Irregular periods
□ PMS
□ Painful intercourse
□ STDS
Birth control type _____
# of pregnancies _____
# of live births _____
# of miscarriages _____
□ Difficulty conceiving
□ Tubal ligation
□ Hysterectomy
□ Ovaries removed
□ Hot flashes
□ Night sweats
□ Menopause
Age _____ Year _____
□ Decreased vaginal lubrication
□ Diminished sex drive

What do you typically eat?
AM:

Lunch:

PM:

Snacks:

Water intake: