

Acupuncture Intake Form

Note: Information provided on this form is confidential.

It is very important the information given is complete and accurate to assist you properly in your healing process.

Please PRINT

Name: _____ Today's Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Age: _____ Occupation _____

Email address: _____ (In order to receive FREE weekly health recommendations I need your email. If you don't like what I have to say, you can always opt out. I promise I will never release your private information to a third party!!)

How did you hear about me? _____

Is this your first experience with acupuncture? Yes No

How do you feel about acupuncture? _____

Are you currently pregnant? Yes No

Are you currently trying to get pregnant? Yes No

Chief Complaint: _____

How long have you had this condition? _____

Onset: Sudden Gradual

What medical diagnosis have you received for this condition? _____

Symptoms relieved by: _____

Symptoms worsened by: _____

What other treatments have you received for this condition? _____

What medications are you taking? _____

Muscles, Joints & Bones

Do you have pain or tightness? No Yes If YES, please check all areas which are affected:

- | | | | | | | |
|--|---|---|--|---|--|--|
| <input type="checkbox"/> Neck
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Upper back (midline)
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Upper back (shoulder blades)
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Shoulders (traps)
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Shoulder Joint
<input type="radio"/> Right <input type="radio"/> Left | | |
| <input type="checkbox"/> Mid-back
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Low-back
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Buttocks
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Hip
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Thigh
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Knee
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Calf/shin
<input type="radio"/> Right <input type="radio"/> Left |
| <input type="checkbox"/> Upper Arm
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Elbow
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Forearm
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Wrist
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Hand <input type="checkbox"/> Finger
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Ankle
<input type="radio"/> Right <input type="radio"/> Left | <input type="checkbox"/> Foot <input type="checkbox"/> Toe
<input type="radio"/> Right <input type="radio"/> Left |

The pain is:

- | | | | |
|--------------------------------------|-----------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Aching | <input type="checkbox"/> Numbing |
| <input type="checkbox"/> Superficial | <input type="checkbox"/> Deep | <input type="checkbox"/> Comes & Goes | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing |

With heat, pain is worse better

With cold, pain is worse better

With pressure, pain is worse better

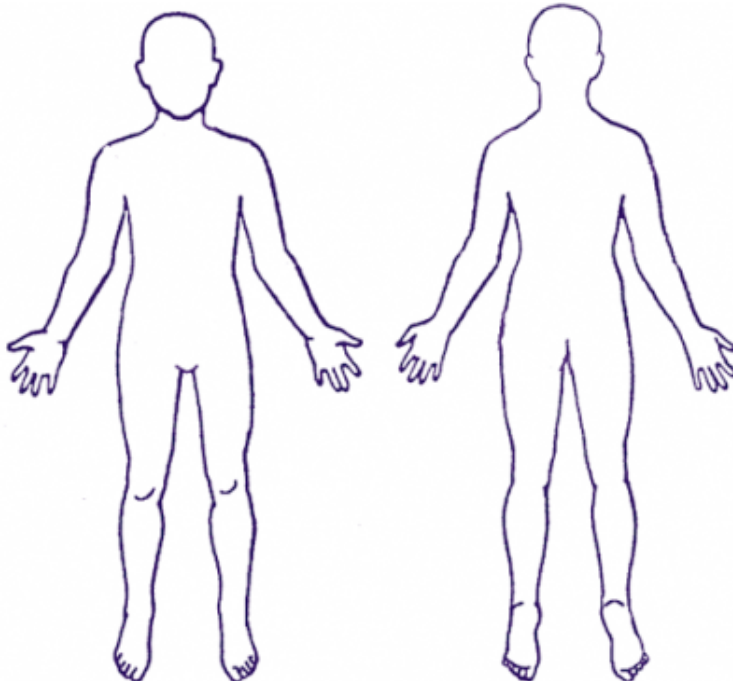
Pain worse in am pm

I have: (check all that apply)

Swollen joints Arthritis/joint pain Tendonitis

Bone pain Muscle cramping Muscle pain

Repetitive Strain Injury Fractured Bone(s): Where? _____



Exercise & Energy

How is your energy? _____

What time of day is your energy:

Highest? _____

Lowest? _____

Do you fatigue easily? _____

What kind of exercise do you do? _____

How often do you exercise? _____

Emotions & Sleep

How do you feel emotionally? _____

Do you have (*check all that apply*):

panic attacks depression anxiety poor memory

difficulty concentrating short temper chronic worry

How do you hold stress? _____

How do you relax? _____

How do you feel about your work? _____

How many hours do you sleep at night? _____

Do you have difficulties with (*check all that apply*):

falling asleep awakening too early dream disturbed sleep

awakening at _____ am/pm

Gastrointestinal Symptoms

- belching nausea vomiting pain after eating hernia
 acid reflux indigestion bloating heart burn

Bowel Movements

How often? _____time(s)/day _____ days/week

I have (*check all that apply*):

- constipation diarrhea gas irregular bowel movements
 burning sensation hemorrhoids itchiness loose stools
 hard stool blood in stool mucous in stool painful movement

Urinary

Urination: How often? _____times/day Color: pale yellow dark yellow

I have (*check all that apply*):

- frequent urination painful urination dribbling
 difficulty starting stream urinary tract infections kidney stones

Female GUT

At what age did you first menstruate? _____ Number of days between cycles _____

Number of days you bleed: _____ Color: _____

I have: (check all that apply)

- Irregular menstruation Heavy flow Light flow
 No flow Clots Vaginal itching/burning
 Spotting between periods Discomfort/ Dysmenorrhea Mid Cycle Spotting/ Pain

Vaginal discharge? No Yes Color: _____

Number of live births: _____ Number of miscarriages or abortions: _____

Male GUT

I have: (check all that apply)

- Prostatitis Impotence Blood/mucous discharge
 Enlarged Prostate Libido EDS

Eyes, Ears, Nose, Throat, & Head

Do you smoke? No Yes _____ per day, for _____ years

I have: (check all that apply)

- Frequent colds Chronic runny nose Frequent sore throat
 Chronic cough Coughing blood Cough up mucous
 Pain on inhaling Asthma Nose bleeds
 Painful/red eyes Poor vision Spots/floaters
 Dizziness Cold sores Bleeding gums
 Dry mouth Ear pain Ringing in ears
 Clogged/popping in ears Shortness of breath on exertion/at rest
 Frequent headaches/migraines

Cardiovascular

I have: (check all that apply)

- Chest pain Palpitation Varicose veins
 Phlebitis Cold hands and feet Irregular heart beat
 Poor circulation Hypertension Hypotension
 Breathlessness

Skin & Hair

I have: (check all that apply)

- Dry skin Skin rashes Itching Acne
 Eczema Hives Hair loss Premature graying