Acupuncture Intake Form

This information is confidential *Date: _____*

Name: _____ Age: _____
Address:_____ Sex: _M / F__
City: _____ State: ____ Zip Code: _____
Phone number: _____
Birth Date: _____
Occupation: _____
Physician: _____ Physician Phone #: _____

Have you ever had acupuncture? Y N

What is your current complaint? _____
_____
How long? _____

What other treatments have you tried? _____
_____

Medications you are currently taking: For what conditions:
_____ _____
_____ _____
_____ _____
_____ _____

Medical History (Check all that apply)

__Aids/HIV	*__Alcoholism/Substance Abuse*
__Allergies to Latex	*__Hepatitis A / B / C*
__Cancer	*__Herpes*
__Emphysema	*__Lyme Disease*
__Diabetes	*__Multiple Sclerosis*
__Heart Disease	*__Pacemaker*
__Seizures	*__Polio*
__Tuberculosis	*__Varicose Veins*

Surgeries: _____
Food Cravings : _____
Food Intolerances? _____
How many glasses do you drink each day of the following per day?
Water _____Soda _____Coffee _____Tea _____Alcohol _____

Do you perspire during the day?_____
Do you perspire at night? _____
Are you always thirsty? _____
Do you prefer drinks that are Hot or Cold?_____
Taste preferences on a scale of 1 to 5, 1 being most liked to 5 disliked:
____Salty ____Sour ____Bitter ____Sweet ___Spicy

Gastrointestinal:
Do you have currently or have you had a major incidence in the past?
____Belching ____Indigestion ____Ulcers
____Hernia ____Nausea ____Vomiting
____Bloating ____Acid Reflux ____Hemorrhoids

Bowel movements: How often? _____day/week
_____Irregularity _____Constipation _____Diarrhea _____Gas

Exercise and Energy:
What kind of exercise do you do? _____How often? _____
How is your general energy level?_____
Are you sedentary or active? _____

Emotions and Sleep:
____Panic Attacks ____Depression ____Anxiety ____Difficulty Concentrating
____Nervous ____Fearful ____Poor Memory

Do you take antidepressants?_____ What kind? _____
Do you take sleeping pills? _____What kind? _____
Difficulty falling asleep _____Restless_____Disturbed Sleep _____
Dreams always_____Waking up in the night_____

Urination:
How many times a day_____Light or Dark in Color _____Bladder Infections _____
Frequent Urination? _____Incontinence _____Burning _____
Do you wake up at night to urinate? _____ Pain during urination? _____

Gynecology:
Are you still menstruating? _
____Heavy flow ____Light flow ____No flow
____Blood clots ____PMS ____Painful periods
____Uterine fibroids ____Cystic breasts

Respiratory:
Do you smoke? No _____times /day for _____years
____Frequent Colds ____Asthma ____Cough ____Cold Sores
____Bleeding Gums ____Dry mouth ____Ear pain ____Migraine
____Ringing in Ears ____Sinusitis ____Excessive Phlegm

Cardiovascular:
____Palpitations ____Varicose Veins ____Cold hands/feet
____Poor circulation ____Dizziness ____Chest pain
____Irregular heart beat ____High blood pressure ____Low blood pressure
____Blood clots

Skin and Hair:
____Dry skin ____Skin rashes ____Itching
____Acne ____Eczema ____Hair loss

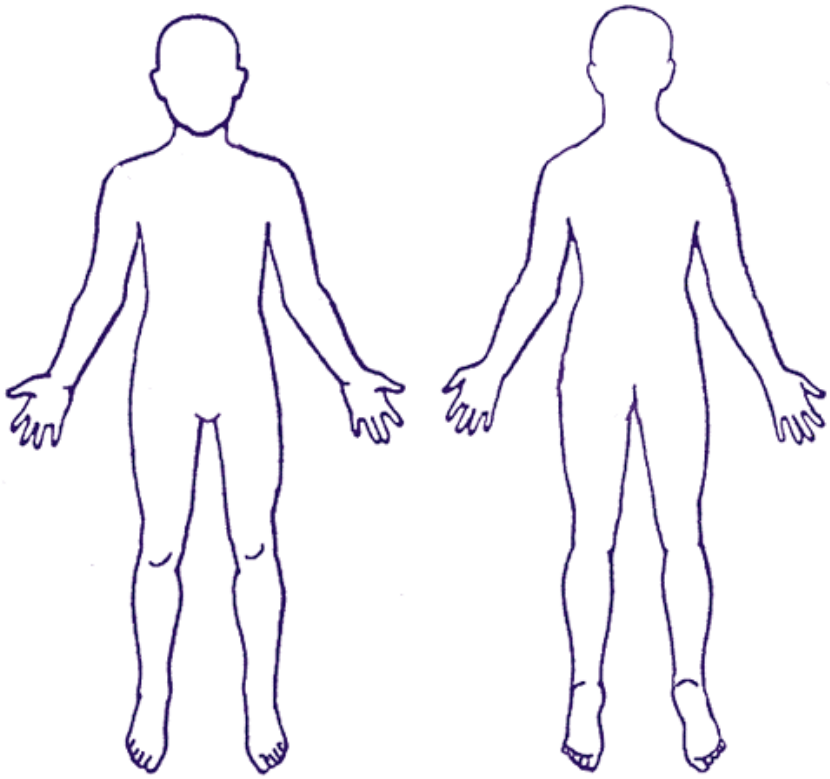
Musculoskeletal:
____Joint pain ____Arthritis ____Muscle tightness ____Numbness
____Tendonitis ____Osteoporosis ____Swelling

*Where is the general area that you are feeling any discomfort?*_____

Chronic or Acute? Usually acute, following poor sleeping habits or postural changes

What number best describes your pain now? 1
No pain 1 2 3 4 5 6 7 8 9 10 Worst pain

Mark with an (X) where you are feeling any discomfort or pain.



If pain, please describe: Sharp Dull Stabbing (please circle)

What makes the pain better? (circle all that apply)
heat cold movement massage rest

*Do you have any additional health conditions?*_____
_____
_____
_____
_____
_____

Print Name _____

Patient Signature _____