



**Acupuncture Intake Form**

Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Insurance carrier: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**In case of emergency notify**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Main Complaint:**

\_\_\_\_\_

**Surgeries/Significant Trauma:**

\_\_\_\_\_

**Medications (please attach if necessary):**

\_\_\_\_\_

**Vitamins/Supplements/Herbs:**

\_\_\_\_\_

**Diet:** Vegetarian Y/N \_\_\_\_\_ Meals per Day \_\_\_\_\_ Caffeine: Drinks/Day \_\_\_\_\_ Alcohol: Drinks/Week \_\_\_\_\_

**Exercise:** Days/week \_\_\_\_\_ Length of workout \_\_\_\_\_ Type of Activity \_\_\_\_\_

**PLEASE, LET US KNOW ABOUT YOUR MAIN COMPLAINTS**

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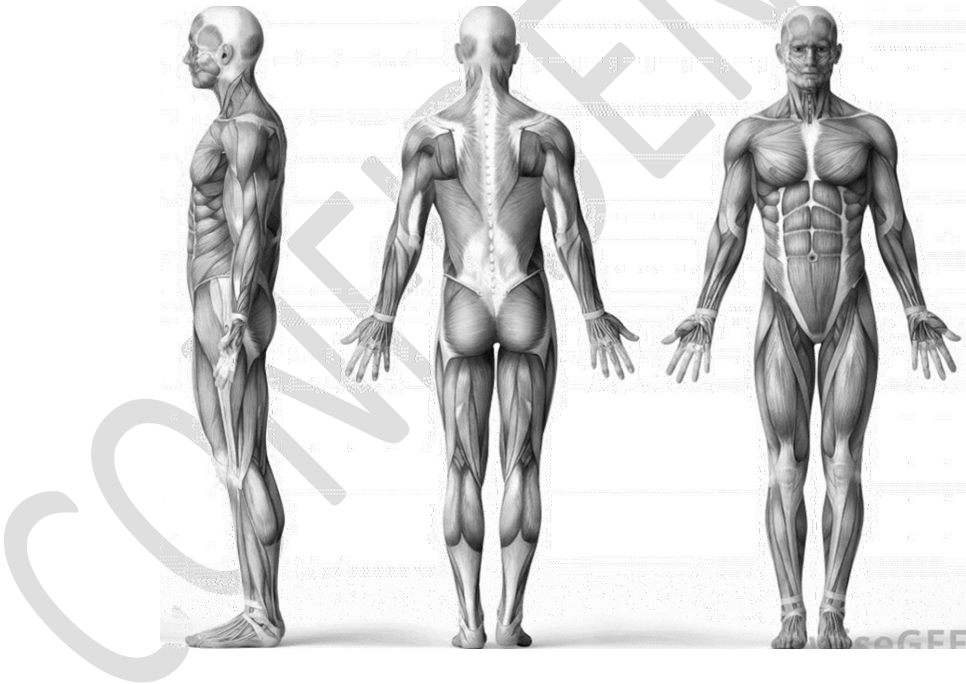
How long has it been since you first noticed any symptoms? \_\_\_\_\_

How does this problem affect your daily activities? \_\_\_\_\_

What kinds of treatment or therapy have you tried? \_\_\_\_\_

Have you ever tried acupuncture? \_\_\_\_\_

**PLEASE MARK PAINFUL OR DISTRESSED AREAS BELOW**



## PERSONAL HISTORY

PLEASE CHECK ANY CONDITIONS OR SYMPTOMS YOU HAVE NOW

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Liver/Gallbladder Disease  | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Disease                   |
| <input type="checkbox"/> High/Low Blood Pressure  | <input type="checkbox"/> Hypoglycemia/Hyperglycemia | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Elevated Blood Cholesterol      |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/Irritable Bowels |
| <input type="checkbox"/> Ulcer                    | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Raynaud's Disease               |
| <input type="checkbox"/> Chronic Fatigue          | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Thyroid Imbalance          | <input type="checkbox"/> Allergies                       |
| <input type="checkbox"/> Fibromyalgia/Polymyalgia | <input type="checkbox"/> Lyme Disease               | <input type="checkbox"/> Chronic Pain Condition     | <input type="checkbox"/> Impotence                       |
| <input type="checkbox"/> Gastritis                | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Emphysema                       |

## FAMILY MEDICAL HISTORY

PLEASE CHECK ANY CONDITION THAT APPLIES TO YOUR IMMEDIATE FAMILY.

PUT AN F (FATHER), M (MOTHER), S (SISTER), B (BROTHER), GM (GRANDMOTHER), GF (GRANDFATHER) NEXT TO CHOICE

- |  |                                    |  |                                 |
|--|------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Seizures  | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Other               |                                    |  |                                 |

PLEASE CHECK IF YOU HAVE HAD ANY OF THESE SYMPTOMS LISTED IN THE LAST THREE MONTHS:

### GENERAL

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Poor Appetite           | <input type="checkbox"/> Poor Sleep                      | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Fevers              |
| <input type="checkbox"/> Chills                  | <input type="checkbox"/> Night Sweats                    | <input type="checkbox"/> Sweat easily           | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Cravings                | <input type="checkbox"/> Localized Weakness              | <input type="checkbox"/> Poor Balance           | <input type="checkbox"/> Change in Appetite  |
| <input type="checkbox"/> Bleed/Bruise Easily     | <input type="checkbox"/> Weight Loss/Gain                | <input type="checkbox"/> Peculiar Tastes/Smells | <input type="checkbox"/> Dental/Gum Problems |
| <input type="checkbox"/> Muscle Weakness/Fatigue | <input type="checkbox"/> Strong Thirst (cold/hot drinks) |   |  |

### SKIN AND HAIR

- |  |                                      |  |  |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Rashes              | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis   | <input type="checkbox"/> Itching       |
| <input type="checkbox"/> Eczema/Psoriasis    | <input type="checkbox"/> Dandruff    | <input type="checkbox"/> Loss of Hair                | <input type="checkbox"/> Moles         |
| <input type="checkbox"/> Skin Discolorations | <input type="checkbox"/> Acne        | <input type="checkbox"/> Change in Skin/Hair Texture | <input type="checkbox"/> Face Flushing |

### HEAD, EARS, NOSE, AND THROAT

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Difficulty Swallowing        | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Eye Glasses          |
| <input type="checkbox"/> Eye Strain             | <input type="checkbox"/> Eye Pain                     | <input type="checkbox"/> Poor Vision            | <input type="checkbox"/> Night Blindness      |
| <input type="checkbox"/> Color Blindness        | <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Blurred Vision         | <input type="checkbox"/> Earaches             |
| <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Poor Hearing                 | <input type="checkbox"/> Spots in Front of Eyes | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Nosebleeds             | <input type="checkbox"/> Recurrent Sore Throats/Colds | <input type="checkbox"/> Teeth Grinding         | <input type="checkbox"/> Facial Pain          |
| <input type="checkbox"/> Headaches (where/when) | <input type="checkbox"/> Dental Problems              | <input type="checkbox"/> Jaw Clicks/Locks       | <input type="checkbox"/> Sores on Lips/Tongue |

### CARDIOVASCULAR

- |  |   |   |                                    |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Palpitations at Rest | <input type="checkbox"/> Fainting  |
| <input type="checkbox"/> Cold Hands/Feet     | <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Varicose/Spider Veins  | <input type="checkbox"/> Pressure in Chest    |                                    |

### RESPIRATORY

- |   |  |   |                                     |
|---|--|---|-------------------------------------|
| <input type="checkbox"/> Cough                      | <input type="checkbox"/> Coughing Blood            | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Pain with Deep Inhalation | <input type="checkbox"/> Tight Sensation in Chest | <input type="checkbox"/> Wheezing   |
| <input type="checkbox"/> Difficult to Inhale/Exhale | <input type="checkbox"/> Production of Phlegm      |   |                                     |

Any Other Lung Condition:

### GASTROINTESTINAL

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Vomiting                 | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Gas                 | <input type="checkbox"/> Belching                 | <input type="checkbox"/> Black Stools               | <input type="checkbox"/> Blood in Stools       |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Bad Breath               | <input type="checkbox"/> Rectal Pain                | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Bloating/Edema      | <input type="checkbox"/> Chronic Use of Laxatives | <input type="checkbox"/> Loose Stools (> 2 per day) | <input type="checkbox"/> Abdominal Pain/Cramps |
| <input type="checkbox"/> Changes in Appetite | <input type="checkbox"/> Acid Reflux              | <input type="checkbox"/> Hernia                     |  |

Any Other Problems with Your Stomach/Intestines:



**UROGENITAL**

<input type="checkbox"/> Pain on Urination	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Urgent Urination
<input type="checkbox"/> Unable to Hold Urine	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Scanty Flow	<input type="checkbox"/> Copious Flow
<input type="checkbox"/> Impotence	<input type="checkbox"/> Sores on Genitals	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Burning Urination
<input type="checkbox"/> Premature Ejaculation	<input type="checkbox"/> Decreased Libido	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Dribbling after Urination

Do You Wake to Urinate?       Yes       No

What Times: \_\_\_\_\_

What Color is Your Urine: \_\_\_\_\_

Any Other Problems with Your Genital or Urinary System? \_\_\_\_\_

**GYNECOLOGICAL/REPRODUCTIVE**

No. of Pregnancies _____	Age of First Menses _____	<input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Breast Lumps
No. of Births _____	Date of Last Menses _____	<input type="checkbox"/> Vaginal Sores	<input type="checkbox"/> Fibrocystic Breast Tissue
No. of Miscarriages _____	Date of last PAP/Pelvic _____	<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Fibroid Tumors
No. of Premature Births _____	<input type="checkbox"/> Painful Menses	<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Infertility
No. of Abortions _____	<input type="checkbox"/> Irregular Menstruation	<input type="checkbox"/> Difficult Intercourse	<input type="checkbox"/> Endometriosis

Are you Pregnant?       Yes       No

Do You Practice Birth Control?       Yes       No

What Type? \_\_\_\_\_

How Long: \_\_\_\_\_

**MUSCULOSKELETAL**

<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Hand/Wrist Pain	<input type="checkbox"/> Carpal Tunnel
<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Sprains/Strains	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Foot/Ankle Pain
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Tendonitis
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Rotator Cuff		
<input type="checkbox"/> Back Pain - lower	<input type="checkbox"/> Back Pain - middle	<input type="checkbox"/> Back Pain - upper	

**NEUROPSYCHOLOGICAL**

<input type="checkbox"/> Seizures	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Vertigo/Dizziness	<input type="checkbox"/> Areas of Numbness
<input type="checkbox"/> Lack of Coordination	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Concussion	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety/Panic Attacks	<input type="checkbox"/> Bad Temper/Irritable	<input type="checkbox"/> Easily Susceptible to Stress	<input type="checkbox"/> Seasonal Affective Disorder

Have you ever been treated for emotional problems?       Yes       No

Do you have a spiritual life?       Yes       No

Have you every considered or attempted suicide?       Yes       No

Have you ever been treated for substance abuse?       Yes       No

Any other neurological or psychological conditions? If yes, please explain: \_\_\_\_\_

Indicate on the scale your satisfaction in family relationships	Satisfied	-----	Distressed
Indicate on the scale your satisfaction in intimate relationships	Satisfied	-----	Distressed
Indicate on the scale your satisfaction in working relationships	Satisfied	-----	Distressed