Acupuncture Patient Intake Form

Please fill in as much information as you can provide. Date_____

PERSONAL INFORMATION

Last Name _____ First Name _____ Age____
Date of Birth _____ Gender: Female_____ Male _____
Occupation_____Height: _____Weight: _____
Phone # (W)_____(H)_____(Cell)_____
Email Address_____
Mailing Address_____
Referred By _____
Emergency Contact
(Name) _____
(Phone number) _____ Relationship _____

Reason(s) for Today's Visit/Health Goals You Would Like to Achieve
1._____
2._____
3._____

How long have you had this condition?_____
Does it affect your: Sleep_____Work_____Other_____
What seemed to be the initial cause?
_____

What seems to make it better?
_____
What seems to make it worse?
_____

PAST MEDICAL HISTORY

Please list all past medical conditions and hospitalizations.
1._____
2._____
3._____

ALLERGIES: please list any life threatening or severe allergies to drugs or foods that you know of: _____
_____
_____

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications/ Supplements:	Reason:	Date began:	Dose:	Helps? Yes or no

Sources and amounts of:

Caffeine/tea:_____cups/day
Soda/pop: _____cups/day
water: _____ cups/day
Alcohol: _____ drinks/ week
Smoking history and amount: _____

Females Only:

Are you currently experiencing any gynecological symptoms or problems?_____

Onset of first menses was age___.
Periods generally last ___ days and occur every ___ days.
Date of last period _____ Bleeding is __Heavy __Moderate __Light
Do you experience PMS symptoms?_____
List:_____
Number of pregnancies?____ Births?____ Abortions?____ Miscarriages?____

Do you use birth control? ☐ Yes ☐ No
If Yes please list the type & brand: _____
_____

Males Only:

Trouble with urination? (Frequency, hesitancy, pain, dribbling)
_____

☐ Impotence/ED ☐ STD ☐ Prostate Problems

FAMILY'S HEALTH: (major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)
Mother _____
Father _____
siblings _____
_____

Please check and describe any problems or change in function in the past or present in any of these areas.

Head & Face
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Light Headedness
- ☐ Red/Itchy/Teary Eye
- ☐ Sinus Trouble
- ☐ Jaw Pain
- ☐ Other

Neurological
- ☐ Anxiety
- ☐ Tremors
- ☐ Numbness/Tingling
- ☐ Loss of Coordination
- ☐ Nerve Pain
- ☐ Other

Sleep
- ☐ Insomnia
- ☐ Difficult to fall asleep
- ☐ Waking easily
- ☐ Drowsiness
- ☐ Excessive Dreaming
- ☐ Nightmares
- ☐ Other

Heart & Chest
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain/Tightness
- ☐ Heart Palpitations
- ☐ SOB
- ☐ Pacemaker
- ☐ Other

Urination
- ☐ Frequent
- ☐ Difficult
- ☐ Painful
- ☐ Burning
- ☐ Other

Skin
- ☐ Acne
- ☐ Dryness/Itchy
- ☐ Excessive Sweat
- ☐ Night Sweats
- ☐ Bruising/Bleeding
- ☐ Cold Hands & Feet
- ☐ Other

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn/Reflux
- ☐ Gas/Bloating
- ☐ Constipation
- ☐ Diarrhea/Loose Stool
- ☐ Excessive or Absent Appetite
- ☐ Excessive or Absent Thirst
- ☐ Vomit/Nausea
- ☐ Other

Musculoskeletal
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Leg pain
- ☐ Back pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Other

Please clearly mark any areas of pain:

Is the Pain ☐ Sharp ☐ Burning ☐ Aching ☐ Sharp ☐ Cramping

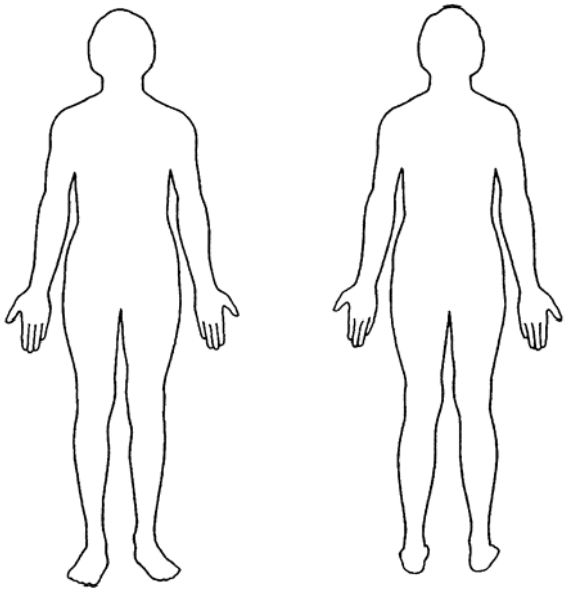
☐ Dull ☐ Moving ☐Fixed ☐ Other: _____

Does the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other:_____

Does the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other: _____



Front Back

Thank you for your time and for filling this form out as completely as possible. Feel free to ask any questions you may have. Please remember all information given is strictly confidential.

Consent Form

I, _____, hereby voluntarily be to be treated with acupuncture. I understand that acupuncture is performed by the insertion of sterile, stainless steel, disposable needles into specific points on the body (small amounts of electrical current may be applied to the needles) to cause a desired healing effect via regulating the flow of Chi (vital energy) in the body. I have been made aware that Traditional Chinese Medicine (TCM) utilizing a range of modalities including, but not limited to the following: acupuncture, cupping, Tuina, Guasha, TDP lamp and herbal therapies to be performed by practitioners at Clinic.

I have been made aware that acupuncture treatment may have some very slight risks. These could include but not limited to some local bruising, minor bleeding, temporary pain or discomfort.

I understand that acupuncture has been safely practiced for centuries. I also understand that results are not guaranteed.

I authorize sharing of relevant health information between the Clinic practitioners for the purpose of analyzing, diagnosing or providing treatment coordination.

I have carefully read and understand all the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

_____	_____	_____
Client Name (Please Print)	Signature	Date
_____	_____	_____
Guardian Name (Under 18 years of client)	Guardian Signature	Date