Wellness with Acupuncture

Patient Intake Form
Note: Information provided on this form is confidential

Name _____ Date of Birth ___/___/___
Address_____
Telephone number (home)_____(cell)_____
Occupation_____
Emergency Contact: _____Tel:_____
Physician_____
Physician's phone #_____

What is your chief complaint?_____
How long have you had this condition?_____
The onset was: □ sudden □ gradual
What makes this condition worse?_____
What makes this condition better? _____
What other treatments have you received for this condition?
_____
Do you have any other complaints, that you would like treatment for? _____
_____

Medical History:
Please check all that apply to you.

__acid reflux
__ asthma
__ allergies
__anxiety
__AIDS/HIV
__arthritis
__back pain
__blurred vision
__breathing difficulties
__cancer
__carpal tunnel syndrome
__chest pain (or tightness)
__chronic fatigue
__constipation
__depression
__diabetes
__diarrhea
__difficult concentrating
__digestion problems
__dizziness/ light headedness
__edema
__fibromyalgia
__frequent urination
__feeling cold
__feeling hot
__foot pain
__gall stones
__gastrointestinal disorder
__gout
__glaucoma
__hepatitis
__hot flashes
__headache
__heart problems
__hives
__high blood pressure
__high cholesterol
__irritable bowel syndrome
__insomnia
__low blood pressure
__lupus
__lyme's disease
__menstrual disorders
__memory loss
__nausea
__neck pain
__numbness & tingling
__night sweats
__palpitation (heart)
__poor appetite
__poor coordination
__persistent cough
__restlessness
__seizure disorder
__shoulder pain
__spinal misalignment
__spinal fusion
__skin problem
__sport injury
__sciatica
__stress
__tendonitis
__tinnitus
__other (please specify)_____

Do you have a pacemaker?_____

Please list any medications, herbs or vitamins you are taking:

_____
_____
_____

Are you on any blood-thinning medications?_____

Please list any past surgeries, serious illnesses or hospitalizations and their dates:

_____
_____
_____

Please describe in detail the health concern (s) you want us to help with

_____
_____
_____

Lifestyle and Nutrition

Do you have a regular eating habit? □Y □N
Do you usually feel hurried for your meals? □Y □N
Do you snack? □Y □N
Do you crave for certain taste or foods? □Y □N
If yes, what do you crave for? _____
Are you a vegetarian? □Y □N
Which of the following do you consume regularly?
Caffeine _____ Sugar _____ Dairy products _____
Fatty food _____ Salty food _____ Cold raw food _____
Do you tend to eat under stress or when you are depressed? _____
Do you exercise regularly? □Y □N
What do you do to exercise? _____

How many hours of sleep do you normally get each night? _____
Do you have trouble falling asleep? □Y □N
Do you have difficulty staying asleep? □Y □N
Do you feel rested when you awake? _____
Are you constantly under stress? □Y □N
How do you manage your stress? _____
Do you use any of the following substances? If you do, how often?
Tobacco _____ Alcohol _____ Recreational drugs _____

Women Only

Are you pregnant? □Y □N

Are you trying to become pregnant? □Y □N

If you are a woman, please describe your menstrual cycle in detail (frequency, color, quantity of flow, any cramps, PMS, backaches etc.)

_____

_____

OTHER QUESTIONS

How are your emotions? _____

Do you get nervous a lot? □Y □N Do you get upset easily? □Y □N

Do you feel sad easily? □Y □N Do you get angry easily? □Y □N

Do you get scared easily? □Y □N Do you get excited easily? □Y □N

Do you ever feel a lump in your throat? □Y □N

Is there anything else you would like me to know? _____

_____

_____

_____

Print Name:_____

Signature:_____ Date___/____/_____