Acupuncture Intake Form

Personal Information

Name _____

Address _____

_____

_____

Home phone_____

Work or cell phone _____

Email _____

Birth date _____Age _____

Number of children_____Ages _____

Marital status _____

Occupation _____

Referred by _____

Physician name_____

Physician's phone_____

Emergency contact name _____

Relationship _____ Phone _____

Main Concerns

Please tell me about your major health and wellbeing concerns in order of how important they are to you. It will help if you include when and where you first noticed them and to what extent they affect your daily life now.

_____

_____

_____

_____

_____

_____

Have you received a diagnosis for your concerns? If yes, what was the diagnosis? _____

_____

What kinds of treatment(s) have you tried or are currently using related to these concerns? _____

_____

_____

What results have you seen from the above treatments? _____

_____

_____

Please mark the severity of your chief concern today.

No problem _____ Worst imaginable

1 2 3 4 5 6 7 8 9 10

Please mark the greatest degree of severity of your chief concern that you have ever experienced.

No problem _____ Worst imaginable

1 2 3 4 5 6 7 8 9 10

Personal Medical History

Please mark all that apply and explain as necessary.

☐ Allergies _____ ☐ Heart disease _____ ☐ Seizures _____

☐ Asthma _____ ☐ Hepatitis _____ ☐ Stroke _____

☐ Cancer _____ ☐ High blood pressure _____ ☐ Thyroid disease _____

☐ Diabetes_____ ☐ HIV/AIDS _____ ☐ Other _____

Please date and describe all hospitalizations and surgeries _____

_____

Please date and describe significant traumas _____

_____

What do you know about your birth (prolonged labor, forceps, premature, etc.) _____

_____

List all known allergies (food, chemicals, drugs, seasonal, insects, etc.) _____

_____

Have you undergone a course of antibiotics lately?_____

Have you been under the care of a licensed health care professional in the past year? _____

If so, for what reasons? _____

Family Medical History

Please mark which apply, elaborate as appropriate and indicate which family member.

☐ Allergies _____ ☐ Drug/alcohol abuse_____ ☐ Seizures _____

☐ Asthma _____ ☐ Heart disease _____ ☐ Stroke _____

☐ Cancer _____ ☐ High blood pressure _____ ☐ Thyroid disease _____

☐ Diabetes_____ ☐ Mental disorder _____ ☐ Other _____

Review of Symptoms

Past	Current	General
☐	☐	Catch cold easily
☐	☐	Recurrent infections
☐	☐	Night sweats
☐	☐	Bleed or bruise easily
☐	☐	Organ prolapse
☐	☐	Strong thirst (hot or cold)
☐	☐	Fatigue/low energy
☐	☐	Sudden drops of energy
		Time of day_____
☐	☐	Sudden change in weight

Past	Current	Skin and Hair
☐	☐	Dry skin/scalp/hair
☐	☐	Rashes/hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Warts
☐	☐	Acne
☐	☐	Change in moles
☐	☐	Hair loss/thinning hair
☐	☐	Graying of hair
☐	☐	Other _____

Past	Current	Sleep
☐	☐	Difficulty falling asleep
☐	☐	Wake up easily during the night
		Times per night? _____
		At a particular time? _____
☐	☐	Wake up too early in the am
		What time? _____
☐	☐	Nightmares
☐	☐	Vivid dreams
☐	☐	Grinding teeth
☐	☐	Talking in sleep
☐	☐	Snoring

Circulation

- ☐ Past ☐ Current Cold hands or feet
- ☐ ☐ Swelling of hands/feet
- ☐ ☐ Blood clots
- ☐ ☐ Varicose veins
- ☐ ☐ Edema/swollen ankles
- ☐ ☐ Puffy eyes

Head, Ears, Eyes, Nose, Throat

- ☐ ☐ Headaches
  Where _____
  When _____
- ☐ ☐ Migraines
- ☐ ☐ Dizziness/vertigo
- ☐ ☐ Fainting spells
- ☐ ☐ Earache
- ☐ ☐ Change in hearing
- ☐ ☐ Ringing in the ears
- ☐ ☐ Blurry vision
- ☐ ☐ Night blindness
- ☐ ☐ Color blindness
- ☐ ☐ Spots before eyes
- ☐ ☐ Dry eyes
- ☐ ☐ Eye pain/sore eyes
- ☐ ☐ Excessive tearing
- ☐ ☐ Glasses/contacts
- ☐ ☐ Facial pain
- ☐ ☐ Facial paralysis
- ☐ ☐ Nosebleeds
- ☐ ☐ Blocked nose/sinuses
- ☐ ☐ Sinus infections
- ☐ ☐ Jaw pain
- ☐ ☐ Teeth/gum problems
- ☐ ☐ Recurrent sore throat
- ☐ ☐ Hoarseness/loss of voice
- ☐ ☐ Tonsillitis/swollen glands
- ☐ ☐ Sores on lips/mouth/gums
- ☐ ☐ Strange taste in mouth
- ☐ ☐ Swollen glands/lumps
- ☐ ☐ Oral ulcers
- ☐ ☐ Other _____

Nervous System

- ☐ ☐ Loss of taste/smell/touch
- ☐ ☐ Tingling sensations/numbness
- ☐ ☐ Tremors
  Where? _____
- ☐ ☐ Lack of coordination/balance
- ☐ ☐ Paralysis or seizures
- ☐ ☐ Stroke
- ☐ ☐ Concussion
- ☐ ☐ Other _____

Chest

- ☐ ☐ Pain in chest
- ☐ ☐ Tightness or pressure in chest
- ☐ ☐ Pain with breathing
- ☐ ☐ Difficulty breathing
- ☐ ☐ Shallow breathing
- ☐ ☐ Shortness of breath
- ☐ ☐ Recurrent/chronic cough
- ☐ ☐ Coughing up blood
- ☐ ☐ Coughing up phlegm
- ☐ ☐ Asthma/wheezing
- ☐ ☐ Production of phlegm
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Heart palpitations or rapid heartbeat
- ☐ ☐ Irregular heartbeat
- ☐ ☐ Other _____

Digestion

- ☐ ☐ Little appetite
- ☐ ☐ Strong appetite
- ☐ ☐ Hunger but no desire to eat
- ☐ ☐ Food cravings
- ☐ ☐ Belching
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Heartburn
- ☐ ☐ Indigestion
- ☐ ☐ Abdominal pain
- ☐ ☐ Regurgitation
- ☐ ☐ Weight loss
- ☐ ☐ Weight gain
- ☐ ☐ Loose stools/diarrhea
- ☐ ☐ Dysentery
- ☐ ☐ Strong smelling stools
- ☐ ☐ Blood in stools
- ☐ ☐ Constipation (< 1 b.m./day)
- ☐ ☐ and dry stools
- ☐ ☐ not daily
- ☐ ☐ with difficulty
- ☐ ☐ Alternating constipation and diarrhea
- ☐ ☐ Gas/flatulence
- ☐ ☐ Hernia
- ☐ ☐ Rectal pain/prolapse
- ☐ ☐ Hemorrhoids
- ☐ ☐ Anorexia nervosa
- ☐ ☐ Bulimia
- ☐ ☐ Bad breath
- ☐ ☐ Other _____

Urinary

- ☐ ☐ Pain on urination
- ☐ ☐ Urgent urination
- ☐ ☐ Frequent urination
- ☐ ☐ Blood in urine
- ☐ ☐ Cloudy urine
- ☐ ☐ Dribbling urination
- ☐ ☐ Urinary incontinence/retention
- ☐ ☐ Incontinence at night
- ☐ ☐ Do you wake to urinate?
  How many times? _____
- ☐ ☐ Bladder/kidney infections
- ☐ ☐ Recurrent yeast infections
- ☐ ☐ Kidney stones

Male System

- ☐ ☐ Prostate problems
- ☐ ☐ Change in sexual drive
- ☐ ☐ Rashes/itching
- ☐ ☐ Genital discharge
- ☐ ☐ Erection difficulty
- ☐ ☐ Low sperm count/motility

Muscles and Joints

- ☐ ☐ Neck pain
- ☐ ☐ Shoulder pain
- ☐ ☐ Back pain
  Where _____
- ☐ ☐ Hand/wrist pain
- ☐ ☐ Knee pain
- ☐ ☐ Foot/ankle pain
- ☐ ☐ Joint/bone problems
- ☐ ☐ Muscle pain/weakness
- ☐ ☐ Tremors/tics in muscles
- ☐ ☐ Osteoporosis
- ☐ ☐ Herniated disc
- ☐ ☐ Sciatica
- ☐ ☐ Other _____

Mind and Emotions

- ☐ ☐ Poor memory
- ☐ ☐ Difficulty concentrating
- ☐ ☐ Depression
- ☐ ☐ Often stressed
- ☐ ☐ Lose control of emotions
- ☐ ☐ Substance abuse
- ☐ ☐ Anxiety/nervousness
- ☐ ☐ Manic behavior
- ☐ ☐ Panic attacks
- ☐ ☐ Easily angered
- ☐ ☐ Aggressive behavior
- ☐ ☐ Other _____

Female System

Past Current

- ☐ ☐ Premenstrual irritability
- ☐ ☐ Clots in menstrual blood
  Color of blood _____
- ☐ ☐ Irregular menses
- ☐ ☐ Painful menses
- ☐ ☐ Heavy/prolonged bleeding
- ☐ ☐ Missed menses
- ☐ ☐ Spotting/abnormal bleeding
- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal dryness
- ☐ ☐ Genital sores
- ☐ ☐ Ovarian cysts
- ☐ ☐ Fibroids
- ☐ ☐ Endometriosis
- ☐ ☐ Breast lumps
- ☐ ☐ Breast swelling or redness
- ☐ ☐ Nipple discharge
- ☐ ☐ Abnormal Pap smear
- ☐ ☐ Infertility
- ☐ ☐ Other _____

Are you pregnant now?_____
Is it possible you're pregnant now?
_____
Are you trying to get pregnant?
_____
Do you practice birth control?
_____

What type and for how long?
_____
Number of pregnancies _____
Number of births _____
Num. of premature births_____
Number of abortions _____
Age of first menses _____
Duration of menses _____
First day of last menses _____
Number of days in cycle _____
Age of menopause _____
Date of last Pap _____

Comments _____
_____

Daily Routines

Please describe your daily activities from when you awake until you go to sleep. Include types of food you eat, exercise, work and other activities.

	Time	Activities, Foods, Routine	Variation
Morning			
Awaken	_____	_____	_____
Breakfast	_____	_____	_____
Activities after breakfast	_____	_____	_____
Midday			
Lunch	_____	_____	_____
Activities after lunch	_____	_____	_____
Evening			
Dinner	_____	_____	_____
Activities after dinner	_____	_____	_____
Night			
Activities	_____	_____	_____
Bed time	_____	_____	_____

List other regular activities not included above. These could be exercise, meditation, spiritual practices, etc. _____
_____
_____

Are you sexually active? Yes_____ No_____ Frequency _____

How many hours per week do you work?_____ Do you enjoy what you do? _____

How far is your commute?_____

How many hours a day do you spend sitting or driving?_____

Other comments about your daily routine _____

_____

General Health Habits

Are you a vegetarian or vegan? Yes_____ No_____ If yes, how long _____

What are the major stressors in your life? _____

How much water do you drink per day? Number of cups _____

Do you exercise regularly? Yes_____ No_____ Length of time_____ Times per week_____

Types(s) of exercise_____

Please mark any of the following that apply.

Aspirin	currently _____	occasionally _____		Diet pills	currently _____	occasionally _____	
Tranquilizers	currently _____	occasionally _____		Vitamins	currently _____	occasionally _____	
Antacids	currently _____	occasionally _____		Sleeping pills	currently _____	occasionally _____	
Laxatives	currently _____	occasionally _____		Herbs	currently _____	occasionally _____	
Cold tablets	currently _____	occasionally _____		Antihistamines	currently _____	occasionally _____	
Ibuprofen	currently _____	occasionally _____		Oral contraceptives	currently ___	occasionally _____	

List any medications you are currently taking _____

Please mark your current use levels of the following:

Tobacco	frequently_____	occasionally_____	never_____	Number of cigarettes per day_____ Age started _____
Alcohol	frequently_____	occasionally_____	never_____	Number of drinks per week_____ Type of drinks _____
Caffeine	frequently_____	occasionally_____	never_____	Number of cups per day_____ Type of drinks _____
Marijuana	frequently_____	occasionally_____	never_____	Number of times per week _____
Ecstasy	frequently_____	occasionally_____	never_____	Number of times per month _____
Cocaine	frequently_____	occasionally_____	never_____	Number of times per month _____
Other	frequently_____	occasionally_____	never_____	Describe _____

Do you have any current or past problems with addiction or substance abuse? Yes_____ No_____

Substance_____ Amount_____ When did you quit? _____

Signature_____ **Date** _____