ACPUNCTURE INTAKE FORM

Date: _____

Name: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Occupation: _____ Employer: _____

Family Physician: _____

Emergency Contact: _____ Phone: _____

Health is more than the absence of disease. It is a state of complete physical, mental and social wellbeing.

What is your reason for today's visit?_____

_____

What (if any) medical diagnosis have you received?_____

_____

What (if any) treatments are you receiving?_____

List all medications and supplements you are taking:_____

Do you have any allergies? _____

List any illnesses, surgeries or trauma (if applicable): _____

_____

EMOTIONS & SLEEP

How would you characterize your emotional life? _____

_____

Please check those that apply to you currently:

□ anxiety □ poor memory □ panic attacks □ difficulty concentrating

□ depression □ fearfulness □ irritability/anger □ racing thoughts

□ confusion □ frequent sighing □ chest tightness □ worry

How would you rate your stress level? Low ◄——————————► High

How do you hold your stress? _____

How do you relax? _____

How many hours of sleep do you get? _____ Do you feel refreshed? Yes □ No □

Please check all that apply. I have difficulty

□ falling asleep □ staying asleep □ dream-disturbed sleep

□ recurrent dreams □ nightmares □ waking up to urinate, _____# of times

□ waking up, with trouble falling back to sleep. What time? _____

GASTROINTESTINAL

Please check all that you experience:

□ bitter taste in mouth □ metallic taste in mouth □ sticky taste □ loss of appetite

□ gnawing hunger □ belching □ nausea □ vomiting

□ heartburn □ indigestion □ ulcers

□ acid reflux □ food cravings, _____

Frequency of bowel movements: _____ x per day/ week

FLUID METABOLISM & URINATION

How much liquid do you consume daily? _____ Are you thirsty? Yes □ No □

What temperature of beverages do you prefer? Hot □ Cold □ Room temperature □

Please check all that you experience:

□ spontaneous sweating □ night sweating □ sweaty palms

□ yellow sweating (can be noticed as stains on armpits or neckline of clothing)

EARS, EYES, NOSE, THROAT & HEAD

Do you experience headaches/migraines? Yes □ No □ How often?

Where are these headaches located?

□ unilateral □ bilateral □ temples □ behind the eyes

□ occipital/neck □ top of head □ forehead □ whole head

□ sinuses □ fixed spot □ moving

What type of pain do they present with?

□ boring/stabbing pain □ dull/achy □ throbbing □ wrapped in towel feeling

□ full □ empty □ stiffness/tight □ bursting

What makes them better?

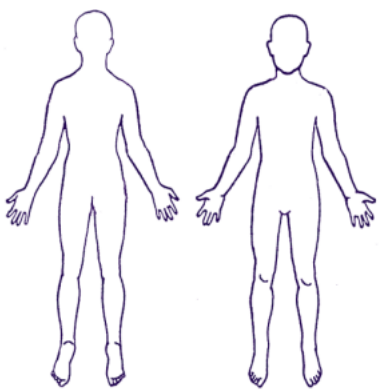
What triggers or aggravates them?

Do you smoke? Yes □ No □ _____ x/day for _____ years. Date quit

How many times per year do you catch colds/flu's? _____ What kind? (ie cold/flu) _____

How do you characterize your body temperature? Hot □ Cold □ Neither □

Does it change at different times of the day? Yes □ No □ How so?



MUSCULOSKELETAL

What type of pain do you experience?

□ wandering pain □ fixed pain □ superficial

□ deep □ stabbing □ pricking

□ burning □ shooting □ sharp

□ dull pain □ aching □ gripping

□ numbness □ tingling □ pins & needles

What makes the pain better or worse?

□ application of cold □ application of heat □ application of pressure

□ rest □ activity □ fatigue

□ stress □ upon waking □ in the evening/night

□ other, please explain _____

FEMALE REPRODUCTION

Age of first menstruation: _____Periods occur every _____ days, lasting _____ days.

Are your periods regular? Yes □ No □ Date of last menstruation. _____

Please check all that you experience. Note if symptoms occur before, during or after menstruation.

□ mood changes □ irritability/anger □ anxiety □ insomnia

□ crying □ forgetfulness □ fatigue □ dizziness/faint

□ abdominal bloating □ increased appetite □ sweet cravings □ salt cravings

□ weight gain □ breast tenderness □ back pain □ cramping

Other: _____

Have you had problems in the past, or currently, with fertility? If yes, please explain.

_____# of pregnancies _____ # of births _____# of miscarriages _____# of abortions

Any complications with pregnancy? If yes, please explain. _____

ASSESSMENT

Pulse:

R:

L:

Tongue: