INTAKE FORM

Name (Last) (First)

Phone Number

Sex ☐ Male ☐ Female Date of Birth Today's date

Home Address

City State Zip Code

EMERGENCY CONTACT

Name Phone Relationship

Referred by

Seeking treatment for what health concerns

Onset date

Has any treatment helped this (these) condition(s)? Please list.

What do you find makes it worse?

Have you ever had acupuncture before? ☐ Yes ☐ No

Please list any pharmaceutical drugs or herbs that you are currently taking.

Please list any surgeries, accidents or injuries that you have had (month/ year)

Please check all that apply:

GENERAL:

☐ Chills ☐ Fever ☐ Low energy/fatigue ☐ Night sweats ☐ Spontaneous sweating ☐ Aversion to heat

☐ Aversion to cold ☐ Recent weight loss ☐ Recent weight gain ☐ Susceptible to colds/flu How many times per year?

EYES/EARS:

☐ Floaters ☐ Blurry vision ☐ Pain behind eyes ☐ Dry eyes ☐ Inflamed eyes /redness ☐ Tearing ☐ Cataract

☐ Glaucoma ☐ Infection ☐ Earache ☐ Ringing in ears ☐ Discharge from ear Other

HEADACHE:

☐ Headaches Which region (forehead, sides, etc.) ☐ Migraines ☐ Tight band headache

☐ Sharp headache ☐ Dull headache ☐ Headache with nausea Other

RESPIRATORY:

☐ Asthma ☐ Difficulty breathing ☐ Difficulty exhaling ☐ Tightness in chest

☐ Phlegm in lungs Color if any Able to bring it up? ☐ Yes ☐ No

☐ Sensation of something stuck in thoat ☐ Coughing up blood ☐ Hoarseness ☐ Loss of voice ☐ Pneumonia

☐ Current history of pneumonia ☐ Hay fever/allergies ☐ Sinus congestion ☐ Nasal mucus Color if any

☐ Loss of sense of smell Other

CARDIOVASCULAR:

☐ Chest pain/angina ☐ Palpitations ☐ High blood pressure ☐ Low blood pressure ☐ Irregular heartbeat

☐ Hypochondriac pain (pain under ribs) ☐ Cold hands or feet ☐ Poor circulation ☐ Ankle swelling

☐ History of heart attack, heart failure Other

GASTROINTESTINAL:

☐ Difficulty swallowing ☐ Bloating ☐ Belching ☐ Gas ☐ Abdominal distension ☐ Constipation ☐ Diarrhea

☐ Burning sensating ☐ Blood in stool ☐ Black stool ☐ Undigested food in stool ☐ Candida/yeast infections

☐ Irritable bowel syndrom ☐ Gout ☐ Hemorroids ☐ No appetite ☐ Insatiable appetite ☐ Nausea

☐ Acid regurgitation/heartburn ☐ Thirst Is thirst quenched by drinking? ☐ Yes ☐ No ☐ Prefer hot/cold drinks

Other

URO-GENITAL:

Urination: ☐ Profuse amount ☐ Urgent/bladder control problem ☐ Scanty amount ☐ Cloudy urine ☐ Frequent urination

☐ Burning sensation ☐ Urine with blood ☐ Current urinary tract infection ☐ History of urinary tract infections

☐ Genital pain/swelling ☐ Genital sores ☐ Impotence ☐ Seminal emissions ☐ Low sexual energy Other

PAIN

☐ Soreness ☐ Dull ☐ Sharp ☐ Inflamed or swollen Radiates to where?

☐ Better with cold ☐ Better with heat ☐ Worse in damp weather ☐ Repetitive stress injury

☐ Result of an accident If so, what type of accident?

NEUROLOGICAL:

☐ Sensation of numbness ☐ Tingling sensation ☐ Sensation of pins and needles

Location for any of these symptoms:

☐ Tremmors ☐ Drowsiness ☐ Fainting ☐ Vertigo ☐ Paralysis ☐ Stroke ☐ Siezure ☐ Loss of balance

☐ Dizziness Other

SKIN/HAIR:

☐ Acne ☐ Eczema/psoriasis ☐ Oily skin ☐ Bruise easily ☐ Dark circles/bags under eyes

☐ Sores/lumps Specific areas

☐ Brittle nails ☐ Dry hair ☐ Hair loss

EMOTIONAL:

☐ Anxiety ☐ Anger ☐ Depression ☐ Difficulty concentrating ☐ Fear ☐ Nightmares ☐ Irritable ☐ Insomnia

☐ Trouble going to sleep ☐ Interrupted sleep If so, what time do you wake up?

Other

WOMEN:

Age at onset of menses Length of cycle (ex., every 28 days) Number of pregnancies

Blood quality: ☐ Dark purple ☐ Bright red ☐ Pale/pink ☐ Clots ☐ Scanty ☐ Heavy

☐ Premenstrual tension ☐ Constipation or diarrhea before or during menses

☐ Feeling of fatigue before or during menses ☐ History of yeast infections/candida ☐ Sores on genitlia

☐ Painful periods ☐ Fibroids ☐ Ovarian cysts ☐ Endometriosis ☐ Abnormal PAP smear ☐ Uterine prolapse

☐ Hysterectomy ☐ C-section ☐ Breast tenderness ☐ Breast lumps Other