ACUPUNCTURE INTAKE FORM

Name _____ Gender M F Age _____

Home Address _____ Home Phone _____

City, Province, Postal Code _____ Work Phone _____

Email Address _____ Cell Phone _____

Birth Date (MM/DD/YY) _____ / _____ / _____

Occupation _____ Hours per week _____

Emergency Contact Person _____

Relationship _____ Phone _____

Physician _____ Phone _____

PURPOSE OF THIS VISIT

Reason for this appointment – Main Complaint _____

Explain _____

When did the condition begin? _____ Any injury or reason? _____

What aggravates your symptoms? _____

What alleviates your symptoms? _____

EXPERIENCE WITH ACUPUNCTURE

Have you ever had acupuncture before? Yes No , if yes, from whom (L.Ac, Chiro, MD, etc)? _____

Reason for visits: _____

How did you respond? _____

HEALTH LIFESTYLE AND CONDITIONS

Do you or have you had any of these conditions? Check all that apply:

☐ AIDS/HIV ☐ Allergies (food, environmental) ☐ Asthma ☐ Cancer

☐ Diabetes ☐ Emphysema ☐ Fibromyalgia ☐ Heart Disease ☐Hepatitis A/B/C

☐ Herpes ☐ Joint Replacement ☐ Lyme's Disease ☐ Lymph Nodes Removed

☐ Pacemaker ☐ Seizures ☐ Tuberculosis

Please list any operations/hospitalizations: _____

Any other information or conditions? _____

Please list any significant family illnesses (eg. Diabetes, heart disease, respiratory conditions, high/low blood pressure, neurological disorders, psychological disorders, arthritic conditions, etc) _____

How is your energy? _____

What time of day is your energy: Highest _____ Lowest _____

Do you fatigue easily? Yes No Explain _____

Do you exercise? Yes No What type? _____ How often? _____

Do you generally feel better and have more energy after exercise or feel more tired? _____

How do you feel emotionally (generally)? _____

Today/Recently: _____

Do you have? Check all that apply:

☐ Panic Attacks ☐ Depression ☐ Anxiety ☐ Short Temper ☐ Poor Memory

☐ Difficulty with concentration ☐ Cry Easily

How or where do you hold stress? _____

What do you do to relax? _____

How many hours do you typically sleep/night? ___ What time do you go to bed? _____ Wake up? _____

Do you have difficulties with? Check all that apply:

☐ Falling Asleep ☐ Staying Asleep ☐ Dream-disturbed sleep

☐ Waking up at about _____ am/pm with difficulty falling back asleep

Do you have pain or tightness? Yes No Where? _____

The pain is: ☐ Acute ☐ Chronic ☐ Onset ☐ Injury _____

☐ Sharp ☐ Dull ☐ Aching ☐ Numb ☐ Superficial Pain

☐ Deep Pain ☐ Burning ☐ Tingling ☐ Shooting ☐ Better with Heat

☐ Better with Cold ☐ Better with Pressure ☐ Worse in AM ☐ Worse in PM

Do you have? Check all that apply:

☐ Swollen Joints ☐ Arthritis/joint pain ☐ Tendonitis ☐ Bone Pain

☐ Muscle cramping/spasm ☐ Muscle Pain ☐ Repetitive Strain Injury ☐ Fractured Bones

Where? _____

Other symptoms? _____

Women Only

Are you currently pregnant? Yes No If yes, when is your due date? _____