Acupuncture Intake Form

Note: Information provided on this form is confidential. It is very important the information given is complete and accurate in order to assist you properly in your healing process.

Name_____Date_____

Date of birth____/____/_____ Age_____ Female □ Male □

Address_____ Apt_____ City_____

State_____ Zip_____ Email_____

**I prefer to contact patients via email for schedule changes. I will never release your private information to a third party or send spam.*

Cell phone_____ Home phone_____

Occupation _____ Employer_____

Work address_____ Work phone _____

Preferred method of contact: □ Cell □ Home □ Work □ Email

□ Married/Partnered □ Single □ Widowed

Emergency Contact _____ Phone_____

Health Insurance Provider_____ Member #_____

Group ID #_____ Mailing Address_____

While some health insurance plans cover acupuncture, many plans DO NOT cover treatment. We will verify your insurance coverage by the second visit and inform you of your benefits. If your plan does not have acupuncture benefits, you will be responsible for the out of pocket expenses.

How did you hear about me?_____

Is this your first acupuncture experience? Yes □ No □

How do you feel about acupuncture? _____

Do you have a phobia of needles? Yes □ No □

Why are you here today?_____

_____

How long have you had this condition or symptoms?_____

_____

What medical diagnosis have you received for this? _____

What other therapies, including medication, are you currently undergoing for this condition?

_____

_____

Symptoms are relieved by _____

Symptoms are worsened by _____

Are you currently pregnant? Yes □ No □ Are you trying to conceive? Yes □ No □

Health History - Conditions you have had in the past.

seasonal allergies□ indoor allergies□ asthma□ alopecia□ anemia□ arthritis□

rheumatoid arthritis□ bipolar disorder□ blood clots□ bleeding gums□ Candida□

congestive heart failure□ COPD □ chronic fatigue syndrome□ diabetes type I □

diabetes type II □ eczema□ epilepsy□ Epstein Barr virus□ fibromyalgia□

gall bladder dysfunction□ hypothyroidism□ hyperthyroidism□ heart condition□ hernia□

high blood pressure□ high cholesterol□ infertility□ irritable bowel □ kidney stones□

kidney infection□ liver dysfunction □ lupus □ Lyme's disease □ measles □ mumps □

Meneire's disease □ migraines□ multiple sclerosis□ neurological dysfunction OCD □

osteoporosis□ osteopenia□ Parkinson's □ rubella □ hysterectomy□ prolapsed uterus□

prolapsed bladder□ PTSD□ psoraisis□ ruptured appendix □ shingles□ scoliosis stroke□

varicose veins□ vertigo□ varicella (chicken pox) □ MRSA □ SIBO □

cancer □ type_____ when_____ method of treatment_____

Surgeries (with dates)_____

Anything I failed to ask about?_____

Muscles, Joints & Bones

Please check any area of the body you experience muscle tension or pain and indicate where.

Neck left ❍ right ❍ center❍ **Upper back/traps** left ❍ right ❍ center ❍
Mid-back left ❍ right ❍ center ❍ **Low Back** left ❍ right ❍ center ❍
Buttocks left ❍ right ❍ **Hip** left ❍ right ❍ **Thigh** left ❍ right ❍ **Knee** left ❍ right ❍
Achille's left ❍ right ❍ **Calf** left ❍ right ❍ **Shin** left ❍ right ❍
Foot left❍ right❍ **Ankle** left ❍ right ❍ **Toe** left ❍ right ❍
Shoulder left ❍ right ❍ **Upper arm** left ❍ right ❍ **Elbow** left ❍ right ❍
Forearm left❍ right❍ **Wrist** left ❍ right❍ **Hand** left ❍ right ❍ **Finger** left ○ right❍
Headaches > tension○ **migraine** ○ **sinus** ○ **frequency**_____

Describe the quality of the pain: (sharp, dull, deep, superficial, burning, shooting, aching, constant, stabbing, numbing, comes and goes)

_____

When did the pain start?_____

Is the pain constant or does it come and go?_____

Does the intensity vary?_____

On a scale of "1 -10", if 1 is minimal, and 10 is extreme, how do you rate your pain? _____

What helps alleviate the pain? (Heat, cold, movement, resting, applying pressure/massage, sitting, standing, lying down, change in weather/humidity, immobilizing the joint)

_____

What intensifies or aggravates the pain?_____

Do you have trouble performing normal daily tasks, if so, what?_____

Do you have limited range of motion or immobility? _____

Ear, Nose, Throat

frequent colds□ chronic runny nose□ frequent sore throat□ asthma □

chronic cough □ dry□ wet □ shortness of breath□ dry mouth□

clogged/popping ears□ sinus headaches □ cold sores□ blurry vision□ watery eyes□

itchy eyes □ itchy nose □ visual floaters□ ringing in the ears□ > high pitch□ low pitch□

Skin & Hair

dry skin □ rashes □ hives □ itching □ acne □ eczema □ premature graying □

loss of head hair □ loss of eyebrows □

Cardiovascular

chest pain□ palpitations□ racing heart□ irregular heartbeat□

varicose veins□ dizziness□ cold hands/feet□ numbness/tingling in limbs□

high blood pressure□ low blood pressure□

Gastrointestinal

burping □ bloating □ indigestion □ heart burn □ pain after eating □ gas□

nausea □ vomiting □ constipation □ diarrhea □ loose stools □

painful bowel movements □ blood in stool □ mucous in stool □ foul smell □

How often do you have a bowel movement?_____

Urinary

frequent urination □ painful urination □ dribbling □ incontinence □ urinary tract infections □

About how many times daily do you urinate?_____ Color light/clear □ dark/scant □

Female Health

Age at first menstruation_____ Are you still menstruating? _____

How many days between cycles (from day 1 to day 1)? _____

How many days do you bleed for?_____

Color pale pink □ bright red □ dull red □ brick red □ brownish □ purple □

Consistency thin/watery □ normal □ thick □

Volume scant □ light □ moderate □ heavy □ flooding □ spotting at onset □

premenstrual symptoms □ spotting between periods □ painful periods □ mid-cycle pain □

mid-cycle bleeding □ ovarian pain □ vaginal pain/burning □ vaginal discharge□

breast tenderness □ fibrocystic breasts □ low libido □ amenorrhea □ infertility □

number of live births _____ number of miscarriages_____

Male Health

enlarged prostate □ impotence □ erectile dysfunction □ testicular pain □ testicular hernia □

sterility □

Emotional & Mental Health

depression ☐ anxiety ☐ moodiness ☐ suicidal thoughts ☐ uncontrollable anger ☐
schizophrenia ☐ obsessive compulsive disorder ☐
attention deficit disorder ☐ memory loss ☐ cognitive dysfunction ☐

Sleep

How many hours do you sleep each night?_____ When is your bedtime most nights?_____

How long does it take you to fall asleep? _____ Do you awaken during the night?_____

If you awaken during the night, at what time(s) typically? _____

Do you fall back asleep easily?_____ When do you usually get up in the morning?_____

Do you feel well rested upon awakening?_____

Lifestyle

How often do you exercise? _____

What type of exercise_____

How many hours do you spend, on average, sitting each day? _____

How is your energy in the morning?_____ After lunch?_____ In the evening?_____

How do you relax?_____

Rank your level of stress on a scale of "1-10", (1 is low, 10 is high) _____

How do you feel about your work? _____

Nutrition (check all that apply)
cook most meals at home ☐ eat out often ☐ fruits/vegetables ☐ grains ☐ meat ☐
fish ☐ dairy ☐ organic ☐ grass-fed ☐ coffee ☐ soda ☐ vegan ☐ vegetarian ☐
Paleo ☐ pescatarian ☐ low carb ☐ low fat ☐ low sodium ☐ intermittent fasting ☐
GaPS diet ☐ lacto-fermented foods ☐ raw ☐ cooked ☐

List supplements you take regularly _____

_____