



Acupuncture & Holistic Health LLC

Acupuncture Intake Form

Note: Information provided on this form is confidential.

It is very important the information given is complete and accurate to assist you properly in your healing process.

Please PRINT

Name: _____ Today's Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Age: _____ Sex: Male Female

Address: _____

Telephone: (Home) _____ (Work) _____

Occupation: _____

Emergency Contact Person: _____

Relationship: _____ Telephone: _____

Primary Physician: _____ Physician's #: _____

How did you hear about us?

- Friend Relative Newspaper
- Website Westfield Street Fair Healthcare referral

Is this your first experience in Oriental Medicine and acupuncture? Yes No

How do you feel about acupuncture? _____

Are you currently pregnant? Yes No

Are you presently trying to get pregnant? Yes No

What do want treated with acupuncture? _____

How long have you had this condition? _____

Onset: Sudden Gradual

What medical diagnosis have you received for this condition? _____

Symptoms relieved by: _____

Symptoms worsened by: _____

What other treatments have you received for this condition? _____

What medications are you taking? _____

Past Medical History

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Drug Addictions | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Allergies (food, latex) | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Replacements | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lymph Nodes removed | <input type="checkbox"/> Other: _____ |

Family Medical History

Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Exercise & Energy

How is your energy? _____

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

Do you fatigue easily? _____

What kind of exercise do you do? _____

How often do you exercise? _____

Emotions & Sleep

How do you feel emotionally? _____

Do you have: (check all that apply)

- Panic attacks Depression Anxiety Depression
- Bad temper Panic attacks Poor memory Difficult concentration

Are you in a relationship? Yes No

How do you feel about your relationship? _____

How do you hold stress? _____

How do you relax? _____

How do you feel about your work? _____

How long do you normally sleep? _____ hours per night

I have difficulties with: (check all that apply)

- Falling asleep Staying asleep Dream-disturbed sleep
- Waking up at about _____ am/pm and not being able to fall asleep again

Gastrointestinal Symptoms

- Belching Nausea Vomiting Vomiting of blood
- Ulcers Bloating Heartburn Acid regurgitation
- Hernia Indigestion Severe Stomach pain

Bowel Movements

How often? _____ time(s)/day _____ days/week

I have: (check all that apply)

- Constipation Diarrhea Gas Irregular bowel movements
- Burning sensation Hemorrhoids Itchiness Undigested food in stool
- Loose Stool Hard stool Blood in stool Painful bowel movements

Urinary Symptoms

Urination: How often? _____ times per day Color: Pale yellow Dark yellow/orange

I have: (check all that apply)

- Trouble starting stream Frequent urination Incontinence
- Pain Burning Blood in urine
- Kidney stones Urinary tract infections

Female GUT

At what age did you start menstruating? _____ Number of days between cycles: _____
Number of days of flow: _____ Color: _____

I have: (check all that apply)

- Irregular menstruation Heavy flow Light flow
- No flow Clots Vaginal itching/burning
- Spotting between periods Discomfort/ Dysmenorrhea Mid Cycle Spotting/ Pain

Vaginal discharge? No Yes Color: _____

Number of Children: _____ Male _____ Female

Miscarriages: No Yes How many? _____ Abortions: No Yes

Male GUT

I have: (check all that apply)

- Prostatitis Impotence Blood/mucous discharge
- Enlarged Prostate Libido EDS

Muscles, Joints & Bones

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

The pain is:

- Sharp
- Dull
- Aching
- Numbing
- Superficial
- Deep
- Burning
- Tingling
- Shooting

- Pain worse/better with heat
- Pain worse/better with cold
- Pain worse/better with pressure
- Pain worse in am/pm

I have: (check all that apply)

- Swollen joints
- Arthritis/joint pain
- Tendonitis
- Bone pain
- Muscle cramping
- Muscle pain
- Repetitive Strain Injury
- Fractured Bone(s): Where? _____

Eyes, Ears, Nose, Throat, & Head

Do you smoke? No Yes _____ per day, for _____ years

I have: (check all that apply)

- Frequent colds
- Chronic runny nose
- Frequent sore throat
- Chronic cough
- Coughing blood
- Cough up mucous
- Pain on inhaling
- Asthma
- Nose bleeds
- Painful/red eyes
- Poor vision
- Spots/floaters
- Dizziness
- Cold sores
- Bleeding gums
- Dry mouth
- Ear pain
- Ringing in ears
- Clogged/popping in ears
- Shortness of breath on exertion/at rest
- Frequent headaches/migraines: _____

Cardiovascular

I have: (check all that apply)

- Chest pain
- Palpitation
- Varicose veins
- Phlebitis
- Cold hands and feet
- Irregular heart beat
- Poor circulation
- Hypertension
- Hypotension
- Breathlessness

Skin & Hair

I have: (check all that apply)

- Dry skin
- Skin rashes
- Itching
- Acne
- Eczema
- Hives
- Hair loss
- Premature graying