ACUPUNCTURE INTAKE FORM

Please complete the following confidential form in detail. Completion of this form allows us to review your treatment plan and provide you with the best care possible.

Date: _____ Date of Birth _____

First Name: _____ MI___ Last Name: _____

email _____ phone _____

Emergency Contact and Phone: _____

Primary Physician & hospital affiliation: _____

Please list any previous surgeries, hospitalizations, and serious illnesses with dates:

_____

_____

_____

What are the main symptoms/problems you are seeking treatment for?

_____ _____

_____

_____

_____

WESTERN MEDICAL DIAGNOSIS

Please check off any Western Diagnosis you have now or have had in the past:

O diabetes	O stroke/heart attack	O multiple sclerosis
O toxoplasmosis	O peripheral neuropathy	O epilepsy/ seizures
O cryptosporidium	O dementia	O attention deficit disorder
O eating disorder	O arthritis	O wasting syndrome
O fibromyalgia	O carpal tunnel syndrome	O allergies to metal
O chronic fatigue syndrome	O pacemaker	O candidiasis
O shingles	O CMV infections	O bacterial septicemia
O endocarditis	O recurrent salmonella	O pelvic inflammatory disease (PID)
O pneumonia: what type_____		O STD : what type
_____		
O cancer: what type _____		O Other:_____

O Allergies: what drugs or substances_____

Please indicate all symptoms below that you have experienced **within the past 30 days**. Please complete this section carefully; these symptoms are all important in obtaining an accurate diagnosis.

Please circle according to the severity of your symptoms
L=Light M=Medium S=Strong

HEAD, EYES, EARS, NOSE, THROAT

L M S sinus problems	L M S nose bleeds	L M S dry mouth
L M S difficulty swallowing	L M S sore throat/mouth	L M S thrush/leukoplakia
L M S headaches	L M S dental/gum	L M S thirst
L M S ear/hearing problems	L M S vision problems	L M S dizziness
L M S sneezing/runny nose	L M S other (specify) _____	

RESPIRATORY

L M S shortness of breath	L M S pain w/deep breath	L M S phlegm
L M S blood in sputum	L M S wheezing	L M S cough
L M S bronchitis	L M S frequent colds	L M S chest pain
L M S other (specify) _____		

GASTROINTESTINAL

L M S loss of appetite	L M S abdominal cramps	L M S nausea
L M S gas/bloating	L M S constipation	L M S diarrhea
L M S weight loss	L M S hemorrhoids	L M S vomiting
L M S heartburn	L M S jaundice	L M S other_____

CARDIOVASCULAR

L M S low blood pressure	L M S high blood pressure	L M S palpitations

GENITO-URINARY

L M S frequent urination	L M S night urination	L M S impotence
L M S low sex drive	L M S pain	L M S edema
L M S genital sores	L M S genital warts	L M S other _____

MUSCULAR/SKELETAL

L M S muscle/joint pain L M S stiff neck/shoulders L M S weakness

L M S pain, tingling or numbness in arms, legs, fingers, toes/ neuropathy

L M S back pain L M S other _____

NEUROLOGICAL/PSYCHOLOGICAL

L M S depression L M S anxiety L M S fear

L M S irritability/anger L M S disorientation L M S forgetfulness

L M S tremors L M S insomnia L M S seizures

L M S poor concentration L M S bipolar L M S other_____

SKIN/HAIR/NAILS

L M S itchy/painful rashes L M S fungus L M S shingles

L M S psoriasis/eczema L M S mole changes L M S cold sores

L M S new KS L M S hair loss L M S acne

L M S bleed/bruise easily L M S other _____

OTHER SYMPTOMS

Describe any symptoms not listed above

_____

_____

_____

OB/GYN Women only-this section.

L M S yeast infections L M S menstrual cramps L M S clots

L M S pelvic infections L M S spotting L M S PMS

L M S mid-cycle pain L M S irregular periods L M S vaginal pain/itching

L M S vaginal discharge L M S no periods L M S hot flashes

L M S other_____

OB/GYN contnued

Menstrual Info: ____ days bleeding ____ day cycle date last period _____
Are you pregnant? O Yes O No O Unknown
Are you in menopause? O Yes O No O Unknown
How many pregnancies have you had? _____ cesarians? _____
Date last pap smear _____ NORMAL ABNORMAL
Last breast exam _____ NORMAL ABNORMAL

WESTERN MEDICATIONS

Please list below all of the medications/supplements/herbs you take:
I do not take any O Western medications O Supplements O Herbs

Medication/Supplement/Herb	**Used to treat**	**Side-Effects Experienced**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Adherence Level: Overall in the past month, have you taken your prescribed medications:

O Almost never O Less than 50% of the time O 50% of the time O Routinely

Client Signature:_____**Date:**_____