

Acupuncture Intake Form

Personal Information

Patient Name: _____

Age: _____ Birth Date: ____/____/____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (Day): _____

Telephone (Night): _____

Telephone (Mobile): _____

Email Address: _____

Occupation: _____

Referral Source: _____

Who is your primary health care provider/MD? _____

Emergency Contact: _____ Phone: _____

Main Complaint

Please identify your major health concerns

1. _____

How long have you had this problem? _____

2. _____

How long have you had this problem? _____

3. _____

• How long have you had this problem? _____

• Have you been given a diagnosis for these problems? _____

• What other treatments have you tried and what were the outcomes? _____

Personal Medical History (Please include your childhood history)

Illnesses	
Surgeries	
Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.)	
Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

General (please check all that apply)

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Weakness | <input type="checkbox"/> Sudden Energy Drops |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Easy to Bleed or Bruise | <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Puffiness or Swelling | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Cravings | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Changes in Appetite | <input type="checkbox"/> Other: | |

Skin & Hair

- | | | |
|--------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Pimples | <input type="checkbox"/> Recent Moles |

Head, Eyes, Ears, Nose, and Throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Toothache | <input type="checkbox"/> Blurry Vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Taste/Smell Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Eye Strain/Pain | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Poor Hearing |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> TMJ Pain |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Spots in Front of Eyes |
| <input type="checkbox"/> Recurrent Sore Throat | <input type="checkbox"/> Lip or Tongue Sores | <input type="checkbox"/> Floaters |

Cardiovascular

- High Blood Pressure
- Cold Hands or Feet
- Swelling of Hands
- Phlebitis

- Low Blood Pressure
- Blood Clots
- Swelling of Feet
- Fainting

- Irregular Heartbeat
- Palpitations
- Chest Pain
- Lightheadedness

Respiratory

- Cough
- Phlegm
- Asthma

- Bronchitis
- Coughing Up Blood
- Painful Breathing

- Difficulty Breathing
- Pneumonia
- Easily Winded

Gastro-Intestinal

- Nausea
- Bad Breath
- Chronic Laxative Use
- Indigestion
- Blood in Stools

- Constipation
- Ulcers
- Vomiting
- Rectal Pain
- Hemorrhoids

- Diarrhea
- Abdominal Pain
- Intestinal Gas
- Belching

Urology

- Painful Urination
- Decrease in Urine Flow
- Cloudy Urine
- Pain in Groin Area

- Urgency to Urinate
- Frequent Urination
- Kidney Stones
- Sexually Transmitted Disease

- Unable to Hold Urine
- Blood in Urine
- Frequent Night Urination

Neuro-Psychological

- Seizures
- Twitches
- Irritability
- Poor Memory
- Tremors

- Areas of Numbness
- Lack of Coordination
- Loss of Balance
- Anxiety

- Concussion
- Depression
- Stress
- Mood Swings

Gynecology

- _____ Age of Menses
- _____ Duration of Menses
- _____ Date of Last Menses
- _____ # of Pregnancies
- _____ # of Births

- Irregular Periods
- Painful Periods
- Breast Lumps
- Spotting
- Vaginal Discharge

- Clots
- PMS
- Menopausal
- Yeast Infections
- Fertility Problems

Musculo-Skeletal

- Arthritis
- Muscle Spasms
- Pain with Weather Changes

- Muscle Weakness
- Scoliosis
- Pain with Activity

- Muscle Cramping
- Weak Joints
- Pain After Waking