Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Sex: Male / Female Phone #:_____

Home Address:_____

City: _____ State: _____ Zip_____ Email address:_____

Emergency Contact Name:_____ Phone #:_____

Reason for visit?_____

_____

Have you experienced acupuncture before? Yes No

How long have you had this condition? _____

What makes it better?_____

What makes it worse? _____

Personal Lifestyle Habits (How much or how often)

Cigarettes (packs)_____ Coffee/Tea _____ Alcohol (per day/week)_____

Marijuana_____ Other recreational drugs_____

Exercise_____

Medicines: Prescription drugs you are currently taking

1. _____ for _____
2. _____ for _____
3. _____ for _____
4. _____ for_____

Surgeries or Hospitalizations

_____

_____

_____

_____

Family History

	Mother	Father	Siblings	Grand Parents	Children
Diabetes					
Mental Illness					
Heart Disease					
Cancer/Tumors					
Stroke					
Allergies					

<u>Infectiouse disease screaning:</u>

__ HIV risks: self or partner
__ TB: self or household
__ Hepatitis
__ History of Sexually transmitted disease
__ Herpes: oral / genital
__ Syphilis / Gonorrhea
__ Chlamydia

Please put a "C" if the condition is current or a "P" if you had it in the past

General
__ Insomnia
__ Dreams / nightmares
__ Irritability
__ Depression
__ Mood swings
__ Fatigue
__ Poor Memory
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Recent weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever

Head & Neck
__ Headaches
__ Migraines
__ Stiff neck
__ Dizziness
__ Fainting
__ Swollen glands

Ears
__ Ringing
__ Hearing loss
__ Infections
__ Earache
__ Hearing aids
__ Vertigo

Eyes
__ Glasses / Contacts
__ Blurred Vision
__ Poor Night Vision
__ Spots or Floaters
__ Eye Inflammation
__ Double Vision
__ Glaucoma / Cataracts

Nose, Throat, Mouth
__ Sinus Infections
__ Hay fever/allergies
__ Frequent Colds
__ TMJ
__ Facial pain
__ Thirst
__ Dry mouth
__ Loss of voice
__ Excessive phlegm
__ Difficulty swallowing

Skin
__ Hives / Rashes
__ Night sweating
__ Dry skin
__ Excessive sweating
__ Easy Bruising
__ Itchiness
__ Eczema / Psoriasis

Respiratory
__ Difficulty Breathing
__ Difficulty to breath lying down
__ Wheezing
__ Asthma
__Wet cough
__ Dry Cough
__ Cough with phlegm
__ Shortness of Breath
__ Tight chest
__ Pneumonia
__ Diagnosed COVID 19

Cardiovascular
__ High Blood Pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitations
__ Irregular heartbeat
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Anemia
__ Heart attack / Stroke

Gastrointestinal
__ Nausea/Vomiting
__ Indigestion
__ Stomach pain
__ Constipation
__ Diarrhea
__ Poor Appetite
__ Excessive hunger
__ Laxative use
__ Bloating
__ Bad breath
__ Acid reflux
__ Bloody stools
__ Mucus in Stools
__ Hemorrhoids
__ Gall Bladder removed
__ Diabetic

Musculoskeletal
__ Joint pain / Disorder
__ Sore muscles
__ weak Muscles
__ Difficulty walking
__ Neck / shoulder pain
__ Upper back pain
__ Lower Back pain
__ Muscle stiffness
__Limited range of motion
__ Other

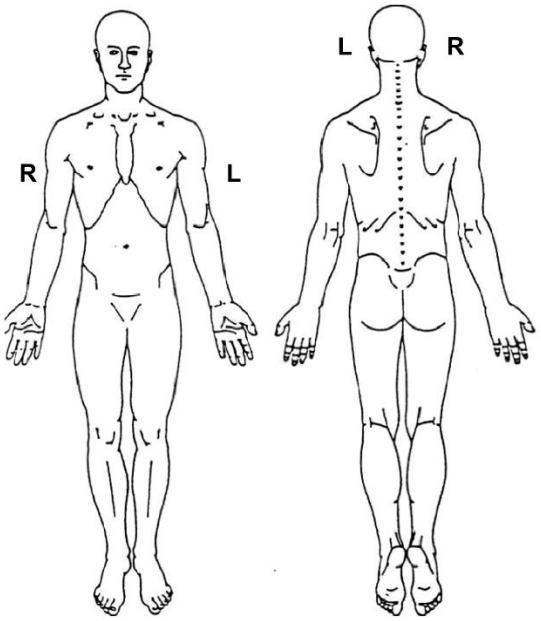
Neurological
__ Seizures
__ Tremors
__ Numbness or tingling
__ Pain
__ Paralysis
__ Poor coordination

Genito-urinary
__ Painful Urination
__ Frequent Urination
__ Urgent Urination
__ Blood in Urine
__ Unable to hold urine
__ Incomplete urination
__ Bed Wetting
__ Wake to urinate
__ Increased Libido
__ Decreased Libido
__ Kidney stones
__ Impotence
__Premature Ejaculation
__ Painful / itchy genitalia

Other:
_____
_____

Acupuncture Intake Form

Please mark on chart areas of concern:



Women Only: Menses

Length _____ Regularity _____

Symptoms associated with menstrual cycle

_____
_____
_____
_____
_____

Number of Pregnancies_____ Number of Births_____ Number of Miscarriages_____

For Physician Use Only

_____
_____
_____
_____
_____
_____
_____
_____
_____