ACUPUNCTURE & WELLNESS CENTER

ACUPUNCTURE INTAKE FORM

This questionnaire is CONFIDENTAL and used to gather information to give you the most effective treatment possible.

Name _____

Address _____

City _____ State_____ Zip _____

Phone Home _____ Work _____ Cell _____

Email _____ Birth date _____

Age_____ Assigned Sex _____ Gender Identity_____ Marital Status _____

Employer _____ Job _____

Primary physician_____

Address _____ Phone _____

Date of last physical examination_____

Other Medical Practitioner (if applicable–ie: Ob/Gyn, PT, OD, etc):_____

Address _____ Phone _____

In emergency:

Contact _____ Relationship _____ Phone _____

Referred by _____

Insurance policy and group# _____

Have you ever had acupuncture before: ❍ Yes ❍ No

MAJOR COMPLAINT (Reason for Visit)

_____

_____

Have you ever had this condition before? ❍ Yes ❍ No

Have you received treatment for this condition? If yes, when? By whom? Did it help?

_____

_____

_____

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What was the medical diagnosis?

Describe what caused it or how it started:

PERSONAL MEDICAL HISTORY:

(Include date) Major Surgeries including Ob/Gyn if applicable, Accidents

Please check if any of the following statements are true for you:

❍ I am taking anticoagulants ❍ I have a pacemaker ❍ I am pregnant

❍ I have allergies: _____

MEDICATIONS, HERBS or SUPPLEMENTS YOU ARE PRESENTLY TAKING:

Condition/Illness	**How Often**

HABITS:

How Often			
Cigarettes		Coffee	
Sugar		Tea	
Salt		Soda	
Recreational Drugs		Other	
Alcohol			

EXERCISE:

❍ Never ❍ Little ❍ Moderate ❍ Heavy

Type of Exercise _____

HOBBIES or INTERESTS:

_____

_____

STRESS LEVEL: ❍ Minimal ❍ Moderate ❍ High ❍ Very High

Main Source of Stress:_____

How long have you been under this stress? _____

EMOTION HEALTH:

❍ Happy ❍ Easily Irritable ❍ Difficulty making decisions ❍ Angry ❍ Cry easily

❍ Hurry to do things ❍ Depression ❍ Stressed ❍ Restless ❍ Overwhelmed

❍ Anxious ❍ Obsessive ❍ Uninterested ❍ Even tempered

❍ Other: _____

RESPIRATORY:

❍ Shortness of breath ❍ Difficulty breathing ❍ Difficulty inhaling ❍ Sigh a lot

❍ Dry cough ❍ Cough with phlegm ❍ Cough with blood ❍ Tightness in chest

❍ Wheezing ❍ Normal ❍ Allergies ❍ Sudden Sadness/Grief

❍ Other _____

CARDIOVASCULAR - CIRCULATION

❍ Palpitations ❍ Chest pain ❍ Low blood pressure ❍ High blood pressure

❍ High cholesterol ❍ Murmur ❍ Irregular heart beat ❍ Varicose veins

❍ Ankle or Hand swelling ❍ Numbness in extremities

❍ Other _____

DIGESTION:

❍ Indigestion ❍ Bloating/Gas ❍ Heartburn/Acid reflux ❍ Nausea ❍ Vomiting

❍ Full feeling ❍ Belching ❍ Abdominal pain or cramps ❍ Food Sensitivities

❍ Difficulty digesting fatty or oily foods ❍ Bitter taste ❍ Excessively worry

O Other _____

BOWELS

❍ Loose stool ❍ Diarrhea ❍ Hemorrhoids ❍ Constipation ❍ Pain or cramps

❍ Use laxatives/fiber ❍ Normal ❍ Other _____

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URINATION (three to four times per day is normal):

❍ Frequent ❍ Burning ❍ Bladder infections ❍ Urgency ❍ Nighttime

❍ Incontinence ❍ Kidney stones or infections ❍ Normal

❍ Other _____

THIRST:

❍ Less than normal ❍ Excessive ❍ Thirsty but do not drink ❍ Prefer cold drinks

❍ Prefer hot drinks ❍ Prefer room temperature ❍ Normal

APPETITE:

❍ Always Hungry or eats excessively ❍ Minimal to No Appetite ❍ Loss of taste

❍ 3 meals a day ❍ Less than 3 meal ❍ More than 3 meals

Do you eat at regular hours? ❍ Yes ❍ No

Cravings: ❍ Sweet ❍ Salty ❍ Spicy ❍ Bitter ❍ Carbohydrates

❍ Other _____

DIET (Typical Foods):

Dairy: ❍ Cheese ❍ Yogurt ❍ Butter ❍ Milk ❍ Ice Cream

How many times/day? _____ Any Sensitivity or Allergy to Casein? _____

Carbohydrates: ❍Whole Grains ❍ White Bread ❍ Cakes ❍ Pasta ❍ Rice

❍ Potatoes ❍ Vegetables

How many times/day for each? _____

_____

Have you ever been tested for Sensitivity or Allergy to Gluten or Corn? _____

Protein: ❍ Beef ❍ Fish ❍ Poultry ❍ Beans ❍ Seeds/Nuts

Vegetables: ❍ Green/Leafy (cooked) ❍ Green/Leafy (raw/salads)

❍ Other veggies regularly eaten: _____

Fruits: type, how much and how often: _____

Special Diet/Food Lifestyle: ❍ Vegetarian ❍ Vegan ❍ Diabetic ❍ Gluten Free

❍ Dairy Free ❍ Other _____

WEIGHT:

❍ Normal ❍ Underweight ❍ Overweight ❍ Recent gain ❍ Recent loss

❍ Difficulty Losing Weight

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ENERGY:

❍ Inconsistent ❍ Low ❍ Normal ❍ Excess ❍ Low after eating

❍ Tired in the afternoon ❍ Other _____

BODY TEMPERATURE:

❍ Warm ❍ Cold ❍ Flushed face ❍ Feel warmer late afternoon ❍ Sweats Easily

❍ Night sweats ❍ Warm Palms ❍ Alternate chills and fever ❍ Profuse Perspiration

❍ Cold hands and feet ❍ Warm soles ❍ Normal

❍ Other _____

SLEEP:

❍ Difficulty falling asleep ❍ Dream often ❍ Tired when get up in morning

❍ Awake easily ❍ Nightmares ❍ Sleep too much ❍ Difficulty going back to sleep

❍ Restless ❍ Normal

Average # hours of sleep: _____

HEADACHES - DIZZINESS:

❍ Headaches ❍ Vertigo ❍ Bend down and stand up and get dizzy ❍ Dizziness

❍ Motion sickness ❍ Poor balance ❍ Faint easily ❍ Migraines ❍ Poor memory

❍ Other _____

SKIN:

❍ Dry ❍ Hives ❍ Itching ❍ Oily ❍ Acne ❍ Bruise easily ❍ Eczema

❍ Normal ❍ Rashes ❍ Cuts heal slowly ❍ Normal

❍ Other _____

Hair:

❍ Dry ❍ Oily ❍ Dandruff ❍ Falling out ❍ Early grey ❍ Normal

NAILS:

❍ Soft ❍ Spots ❍Grow slowly ❍ Ridges and lines ❍ Purple ❍Yellow

❍ Break easily ❍ Pale ❍ Normal ❍Other _____

EYES:

❍ Wear glasses/ contacts ❍ Eyelids swollen ❍ Red ❍ Dry ❍ Itch

❍ Poor night vision ❍ Twitch ❍ Painful ❍ Sensitive to light ❍ Color blindness ❍

Tear easily ❍ Normal Other _____

EARS:

❍ Poor hearing ❍ Ringing (high pitch) ❍ Ringing (low pitch) ❍ Discharges

❍ Ear aches ❍ Normal ❍ Other _____

NOSE:

❍ Stuffy nose ❍ Sneeze a lot ❍ Environmental sensitivity ❍ Bleeding

❍ Loss of smell ❍ Sinusitis ❍ Normal ❍ Other _____

MOUTH & THROAT:

❍ Dry ❍ Gum problems ❍ Difficulty swallowing ❍ TMJ ❍ Feel lump in throat ❍ Mouth sores ❍ Grind teeth ❍ Normal ❍ Other _____

FAMILY MEDICAL HISTORY: **Illness/date**

Mother	
Father	
Sibling	
Children	
Other	

******* FOR FEMALES ONLY *******

Are you or might you be pregnant? ❍ Yes ❍ No ❍ Not Sure

If yes, date of conception? _____

# of Pregnancies: ____Births ____Miscarriages ___Stillborn ____Abortions

Any Pregnancy or Childbirth _____

Complications? _____

Do you use Birth Control? ❍ Yes ❍ No

Type and for how long: _____

In what menstrual stage are you in?

❍ pre-menopausal ❍ menopausal ❍ post menopausal

Any menopausal symptoms? _____

_____

Are you experiencing reduced sex drive? ❍ Yes ❍ No

Other difficulties? EXPLAIN: _____

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When was your last gynecological exam? _____

Findings? _____

Vaginal Discharge: ❍Yellow ❍Thick ❍ Bad Odor ❍ White ❍ Clear ❍ Other

Do you have regular breast exams? ❍ Monthly ❍ Yearly ❍ Never

Last mammography: _____

Do you have facial hair or excess body hair? ❍ Yes ❍ No

MENSTRUAL CYCLE AND FERTILITY: (Please check and explain as applicable)

Age started _____ Days of flow _____ Age stopped _____ Date last period_____

How many days from the beginning of your period to the start of your next period? ____

❍ Irregular Painful ❍ Heavy flow ❍ Scanty flow ❍ Dark Color flow ❍ Light color flow

❍ Clotting ❍ Spotting between periods ❍ Water Retention ❍ Abdominal bloating

❍ Painful or tender breasts ❍ Breast lumps ❍ Emotional changes

❍ Lump in throat feeling ❍ Constipation and/or diarrhea ❍ Tightness in chest ❍

Hormonal problems ❍ Backache ❍ Pinching in lower abdomen with Ovulation

❍ Other _____

Have you been unsuccessfully trying to conceive and/or been diagnosed with Infertility?

_____

Have you and your partner been evaluated by a Fertility Specialist? ❍ Yes ❍ No

If Yes, what were the findings? _____

Are you scheduled or in the process in Fertility Treatments? ❍ Yes ❍ No

What is the Fertility Treatment Plan? _____

_____

GYNECOLOGICAL HISTORY AND OPERATIONS:

_____

_____

******* FOR MALES ONLY *******

❍ Swollen Testes ❍ Testicular Pain ❍ Premature Ejaculation

❍ Low or Irregular Sperm Count Date last tested: _____

❍ Feelings of coldness or numbness in external genitalia ❍ Decreased Libido

Latest Prostate Exam/Results: _____

Other: _____