

Acupuncture Intake Form

Personal Information

Patient Name: _____ Preferred Name: _____

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

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: _____

Health insurance: _____ Is Acupuncture a covered benefit? _____

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)

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

Skin & Hair

- | | | |
|--------------------------------------|----------------------------------|---------------------------------------|
| ☐ Rashes | ☐ Itching | ☐ Dandruff |
| ☐ Skin Ulcers | ☐ Eczema | ☐ Hair Loss |
| ☐ Hives | ☐ Pimples | ☐ Recent Moles |

Head, Eyes, Ears, Nose, and Throat

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