

# 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