Acupuncture Intake Form

Name ____________________________ Date ______________________

Address __________________________ Date of birth _______________ Age ___

__________________________ Place of birth ______________

Phone (H) _____________________ Height ________ Weight _______

(W) _____________________ Referred by ____________________

Occupation ____________________

Marital status __________________

Number of children _____________

In case of emergency, notify ____

name phone(s)

Name of Doctor ____

Have you had previous care by: chiropractor counselor

(please circle) acupuncturist massage therapist other

CHIEF COMPLAINT

State your present complaint, injury, or illness and give a brief account of history and development:

____

____

____

____

PERSONAL HEALTH HISTORY

Circle any of the following conditions you currently have, or have had in the past:

AIDS/HIV	hepatitis	seizures
alcoholism	herpes	stomach or intestinal disorder
allergies	high blood pressure	stroke
arthritis	high cholesterol	thyroid disorder
asthma	kidney disorder	tumor
cancer	liver/gall bladder disorder	ulcers
diabetes	multiple sclerosis	venereal disease
emphysema	pace maker	other (specify) _______________
epilepsy	parasites	
heart disease	pneumonia	

Surgeries and hospitalizations ____

____

Major trauma (car accident, falls, concussion, etc.) ____________________________________

____

MENSTRUAL AND PREGNANCY HISTORY

Age periods began ________

Are you still having periods? Yes _____ No ____

If yes, how long is your cycle? (day 1 to day 1) ____________

When was the first day of your last period? ____________________

Was it normal? ____

How many days do your period last? (duration of flow) __________

Do you have bleeding between periods? Yes ____ No ____ Sometimes _____

Date of last Pap smear __________________ Result ________________________

Are you pregnant? ______ Months ______

Live births _____ Any complications? __________________________________

Miscarriages _____

MEDICINES

Please circle any of the following that you are now taking:

aspirin	antacids	allergy medication
ibuprofen	laxatives	sleeping pills
cold tablets	diet pills	oral contraceptives

Please list any medications you are currently taking:

____

____

____

Please list any herbs or vitamins you are currently taking:

____

____

____

LIFESTYLE

Do you use: (circle) tobacco tea coffee soft drinks alcohol recreational drugs artificial sweeteners

How often? ____

What type of exercise do you do? How often? __________________________________

Do you consider your life to be stressful? What do you do for stress management?

____

What foods do you eat most often? ____

____

Signature _____________________________________ Date ___________________

Please circle current symptoms:

HEAD & FACE
- dizziness or vertigo
- fainting
- headaches
- migraine
- TMJ

EARS
- earache
- ringing in ears
- poor hearing

EYES
- glasses
- eye pain
- red eyes
- itchy eyes
- blurred vision
- poor vision
- visual changes
- poor night vision
- spots in eyes
- eye inflammation

NOSE, THROAT, & MOUTH
- Nosebleed
- hay fever or allergies
- sinus problems
- excessive phlegm
  - color of phlegm ________
- sore throat
- hoarseness
- lumps in throat
- enlarged lymph glands
- teeth problems
- grinding teeth
- gum problems
- dry mouth
- excessive saliva
- oral sores

SKIN & HAIR
- acne
- rashes
- eczema
- psoriasis
- ulcerations
- dryness
- itching
- hair loss
- fungal infections
- changes in moles or lumps
- water retention

RESPIRATORY
- difficulty breathing when lying down
- asthma/wheezing
- shortness of breath
- coughing blood
- cough
  - wet or dry ____________
  - color of phlegm _______
  - thick or thin __________
- frequent colds

CARDIOVASCULAR
- palpitations
- chest pain/tightness
- rapid heart beat
- irregular heart beat
- poor circulation
- swelling of ankles

GASTROINTESTINAL
- nausea
- vomiting
- vomiting blood
- indigestion
- stomach pain
- intestinal pain or cramping
- acid regurgitation
- bad breath
- gas
- poor appetite
- heavy appetite
- eating disorder
- bloating
- diarrhea
- constipation
- blood in stools or black stools
- mucus in stools
- hemorrhoid
- burning anus
- recent change in weight
- food cravings
- peculiar taste in mouth
- food allergies

MUSCLE & JOINT
- joint pain
- limited range of motion
- neck/shoulder pain
- muscle pain
- weak muscles
- carpal tunnel syndrome
- repetitive use syndrome
- spinal curvature
- spinal problems
- back pain
- sciatica
- osteoporosis

GENITO-URINARY
- pain on urination
- frequent urination
- urgent urination
- weak urinary stream
- unable to hold urine
- blood in urine
- incomplete urination
- wake to urinate
- increased libido
- decreased libido
- kidney stone
- pain/itching of genitalia
- genital lesions/discharge
- impotence

GYNECOLOGY
- vaginal infections/discharge
- vaginal sores
- abnormal Pap smear
- irregular periods
- painful periods
- bleeding between periods
- abnormal bleeding
- premenstrual syndrome
- pelvic inflammatory disease
- pelvic surgery/hysterectomy
- menopausal symptoms
- breast lumps

NEURO-PSYCHOLOGICAL
- easily stressed
- irritability
- anxiety
- depression
- abuse survivor
- considered/attempted suicide
- seeing a therapist
- tremors or ticks
- numbness or tingling
- paralysis

GENERAL
- poor sleep
- heavy sleep
- frequent dreams/nightmares
- poor memory
- fatigue
- strongly like cold drinks
- strongly like hot drinks
- bodily heaviness
- cold hands or feet
- fever
- chills
- night sweats
- sweat easily
- thirst
- bleed or bruise easily
- muscle cramps

Informed Consent and Release
For
Acupuncture Treatment

By signing below, I do hereby give consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine. Methods of treatment may include, but are not limited to: acupuncture, herbal formulae, moxibustion, Tui Na Chinese massage, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including but not limited to bruising, numbness, or tingling near a needling site that may last a few days, and dizziness or fainting.

The herbs and nutritional supplements that may be recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes or hives. I understand that herbal formulae need to be prepared and consumed in accordance with the instructions provided. I will immediately notify the acupuncturist of any unpleasant effects associated with herbal teas and products.

I understand that it is my responsibility to notify the acupuncturist of any existing conditions or changes in my current condition or situation. This includes physical and emotional conditions and changes in them associated with treatment, side effects of treatment, or pregnancy.

I understand that acupuncture and Chinese herbal therapy are not substitutes for conventional medical care. If there is reason to believe that I have a serious medical condition, it is my responsibility to seek appropriate care.

I understand the benefits and risks of acupuncture and that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I agree to give 24 hours notice of cancellation of appointments. If less than 24 hours notice is given, I agree that the acupuncturist may charge for the time which was reserved for me.

Patient's name (please print) ______________________________

Patient's signature ______________________________________

Date ________________