Acupuncture Intake Form- General

Today's date________________________________

Name: ____ Age_________ DOB ________________________
Address____
Best contact phone # ______________________________ Email address ____

Reason for today's visit: ____
How long have you had this condition? _______________ What seemed to be the initial cause?______________________________
Is it getting worse? (Yes / No) What seems to make it better /worse? ____
Any other health concerns?____
Have you had acupuncture before? (Yes/N0) When was your last treatment?__________ What is your Blood Type? (A, B, AB, O, or ?)
Other therapies you are currently receiving? ____
Current medications and supplements?____

General History:

❑ Allergies	❑ Elevated Cholesterol	❑ Reproductive Issues _____________
❑ Anemia	❑ Heart Disease	❑ STDs _______________________
❑ Arthritis	❑ Hepatitis	❑ Skin Conditions _______________
❑ Asthma	❑ Herpes	❑ Thyroid Disorders
❑ Autoimmune Disease: ________________________	❑ HIV/ AIDS	❑ Tuberculosis
❑ Cancer: ___________________	❑ High Blood Pressure	❑ Urinary Incontinence
❑ Diabetes Mellitus	❑ Low Blood Pressure	❑ Other___________________________
	❑ Osteoporosis	❑ _________________________________

Family History:

____
____

General Symptoms

□ Poor appetite
□ Heavy appetite
□ Strongly like cold drinks
□ Strongly like hot drinks
□ Peculiar taste
□ Cravings
□ Sweats easily
□ Night sweats
□ Poor sleep
□ Dream disturbed sleep
□ Heavy sleep
□ Bodily heaviness
□ Chills
□ Fever
□ Bleed or bruise easily
□ Cold hands or feet
□ Poor circulation
□ Vertigo or dizziness
□ Fatigue
□ Lack of strength
□ Shortness of breath
□ Muscle cramps

Head, Eyes, Ears, Nose, Throat

□ Headaches
□ Migraines
□ Facial pain
□ Glasses
□ Poor vision
□ Blurred vision
□ Eye strain
□ Red eyes
□ Itchy eyes
□ Spots in eyes
□ Glaucoma
□ Night Blindness
□ Sores on lips or tongue
□ Swollen glands
□ Dry mouth
□ Excessive saliva
□ Recurrent sore throat
□ Lumps in throat
□ TMJ
□ Teeth problems
□ Grinding teeth
□ Sinus problems
□ Enlarged thyroid
□ Excessive phlegm
□ Earaches
□ Ringing in ears
□ Poor hearing
□ Gum problems

Respiratory

□ Difficulty breathing when lying down
□ Shortness of breath
□ Tight chest
□ Cough Wet or dry?
□ Color of phlegm ________________
□ Coughing blood
□ Asthma/ wheezing
□ Pneumonia

Cardiovascular

□ High Blood Pressure
□ Tight chest
□ Blood clots
□ Fainting
□ Difficulty breathing
□ Heart palpitations
□ Irregular heart beat

Gastrointestinal

Bowel movements:
Frequency:______________________
Texture/Form___________________
Color:__________________________
Odor___________________________
□ Diarrhea
□ Constipation
□ Laxative use
□ Mucous in stools
□ Itchy anus
□ Anal fissures
□ Black stools
□ Bloody stools
□ Gas
□ Bloating
□ Intestinal pain or cramping
□ Burning anus
□ Rectal pain
□ Hemorrhoids
□ Nausea
□ Vomiting
□ Acid regurgitation
□ Bad breath
□ Hiccup

Musculoskeletal

□ Joint pain
□ Muscle pain
□ Neck/ shoulder pain
□ Upper back pain
□ Lower back pain
□ Rib pain
□ Limited range of motion
□ Limited use

Skin and Hair

□ Rashes
□ Eczema
□ Dandruff
□ Hair loss
□ Change in hair / skin texture
□ Hives
□ Psoriasis
□ Itching
□ Fungal infections
□ Ulcerations
□ Acne

Neuropsychological

□ Seizures
□ Poor Memory
□ Irritability
□ Numbness
□ Depression
□ Anxiety
□ Easily stressed
□ Tics
□ Abuse survivor
□ Considered/ attempted suicide

Genito-urinary

□ Pain when urinating
□ Blood in urine
□ Venereal disease
□ Increased libido
□ Impotence
□ Frequent urination
□ Bedwetting
□ Unable to hold urine
□ Decreased libido
□ Premature ejaculation
□ Wake to urinate
□ Incomplete urination
□ Kidney stone
□ Nocturnal emission

Your Diet

Appetite □ Low □ Strong □ Too Busy to Notice

□ Coffee (#/day)___
□ Sugar
□ Salty food
□ Soft Drinks
□ Artificial sweeteners
□ Processed/Packaged foods?
□ Thirst for water
# of glasses per day________
□ meat (#/wk)
____
□ dairy (#/wk)
____

Yesterday's
Breakfast____Lunch____
Dinner____Snacks__________________________________Is this a typical day? Y or N

Your Lifestyle

□ Alcohol
□ Tobacco
□ Drugs
□ Marijuana
□ Stress
□ Occupational Hazards
□ Regular Exercise: Type____ Frequency:__________________

WOMEN ONLY…Menstrual History:

Date of last menstrual period: _________________ At what age did you begin your menstruation? □ < 11 □ 11 □12-14 □15 □ >15
Is your menstrual cycle regular? (i.e.: 28 days long?) (Yes/ No) What is the duration of your flow? □ <3 days □ 3-6 days □>6 days

How is your overall flow? □ Light □ Moderate □ Heavy
How is your clotting during menstruation? □ None □ Few □ Moderate Size of your clots? □ Small □ Medium □ Large
How are your menstrual cramps? □ None □ Moderate □ Severe
How long do your cramps last? □ Hours □ Days
Do you have irregular bleeding outside of your menstruation? (Yes / No)

What are the symptoms you experience pre-menstrually? (Please check all that apply.)

□ Anxiety □ Mood Swings □ Nervousness □ Fluid Retention □ Headaches □ Food Cravings □ Tender Breasts □ Difficulty Sleeping □ Constipation