

Acupuncture Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Patient Information (Please Print)

Name: _____ Date of First Visit: _____
Date of Birth: _____ M / F Occupation: _____
Address: _____ Postal Code: _____
Phone: (H) _____ (W) _____ (Cell) _____
Email Address _____ Preferred method of contact: Home Cell Email
Primary Doctor: _____ Phone _____
Emergency Contact Name: _____ Phone: _____
How did you hear of us? _____

Have you ever had Acupuncture before? YES NO

What is your primary reason(s) for treatment today?

Have you visited a medical doctor for this condition? YES NO

If yes, did you receive a diagnosis? NO YES: _____

Are you currently receiving any other treatments for this condition? YES NO

If yes, please describe treatments and how effective they have been: _____

Please list any current medications (prescription and over the counter), vitamins, supplements, herbs or homeopathic remedies that you are taking, including dosage if you know it

For females: Are you pregnant? NO Possibly YES How far along? _____

Do you have a contagious disease at this time? NO YES: _____

If you are seeking treatment for a painful condition, please describe the pain and shade in areas of pain on the diagram below

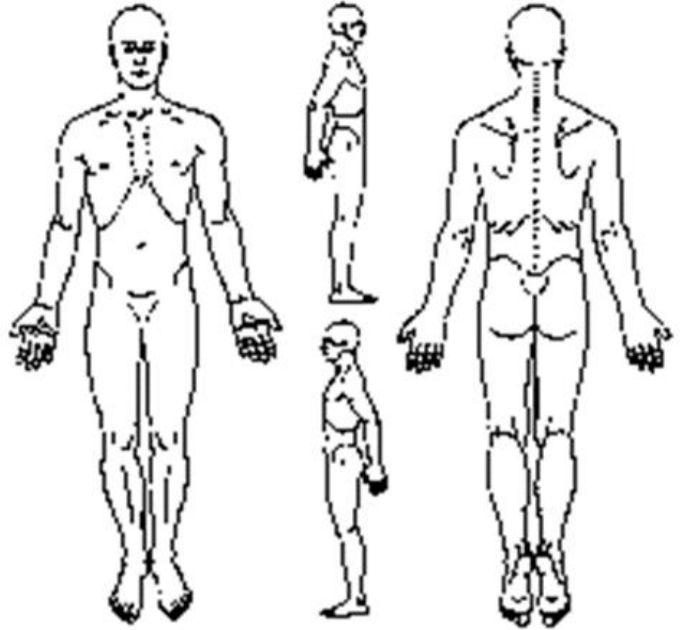
Pain Condition #1 Degree of pain (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain

- Constant
- Comes and goes
- Fixed
- Moves
- One side
- Both sides
- Sharp
- Dull
- Burning
- Aching
- Spastic
- Numb

Does the pain get better, or worse with?

- Heat better worse
- Cold better worse
- Motion better worse
- Rest better worse
- Pressure better worse
- Better in AM or PM?



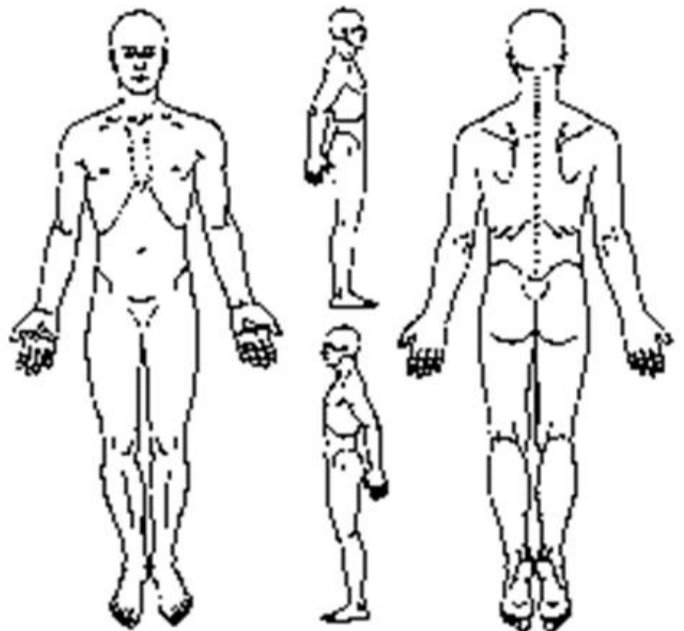
Pain Condition #2 Degree of pain (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain

- Constant
- Comes and goes
- Fixed
- Moves
- One side
- Both sides
- Sharp
- Dull
- Burning
- Aching
- Spastic
- Numb

Does the pain get better, or worse with?

- Heat better worse
- Cold better worse
- Motion better worse
- Rest better worse
- Pressure better worse
- Better in AM or PM



Do you have any of the following?

- Pacemaker
- Surgical replacements
- Implants
- Other allergy _____
- Hemophilia
- Sensitive skin
- Fear of needles
- Latex allergy
- Nut allergy

Is There Family History of:

- Alcoholism
- Allergies
- Asthma
- Bleeding disorders
- Cancer
- Other _____
- Depression
- Diabetes
- Heart disease
- High blood pressure
- Kidney disease
- Mental illness
- Seizures
- Stroke

How much do you consume per day of:

- Water _____ Coffee _____ Tea _____ Soda _____ Alcohol _____ Cigarettes _____
- Generally, do you prefer warm drinks cold drinks room temperature drinks?
- Do you find that you are always thirsty rarely thirsty or thirsty for sips later in the day?

What are your typical eating habits?

- Skip Meal(s) _____
- Eat in a Rush
- Eat When Not Hungry
- Craving specific food(s) _____
- Other: _____
- Eat too Fast
- Cannot eat when Worried/Stressed
- Excess Hunger
- No Desire to Eat
- Eat late at night

What are your typical sleeping habits?

- Hours slept/night _____
- Fall asleep quickly
- Trouble falling asleep
- Difficulty waking up
- Other _____
- Trouble staying asleep
- Deep sleeper
- Light sleeper
- Frequent dreaming
- Disturbing dreams
- Wake at same time every night _____

How would you describe your energy levels?

- High
- Low
- Other _____
- Normal
- Lethargic
- Hyperactive
- Changes from day to day

Do you have aversion to any of the following?

- Cold
- Wind
- Other _____
- Dampness
- Heat
- Loud Noises
- Crowds

What is your Average Body Temperature?

- Hot
- Cold
- Other _____
- Cold Hands & Feet
- Hotter @ Night
- Colder @ night
- 5 Center Heat
- Hot Joints

General Information

- | | | |
|---|--|---------------------------------------|
| <input type="radio"/> Anorexia/Bulimia | <input type="radio"/> Lupus | <input type="radio"/> Mumps |
| <input type="radio"/> Chronic Fatigue | <input type="radio"/> Lyme disease | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Chicken Pox | <input type="radio"/> Meningitis | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Chronic Pain | <input type="radio"/> Scarlet Fever | <input type="radio"/> Overactive |
| <input type="radio"/> Fibromyalgia | <input type="radio"/> Mononucleosis | <input type="radio"/> underactive |
| <input type="radio"/> Hepatitis _____ | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Measles |
| <input type="radio"/> HIV | <input type="radio"/> Rheumatoid Disease | <input type="radio"/> Pneumonia |
| <input type="radio"/> Herpes/Cold Sores | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Cancer: _____ | | |
| <input type="radio"/> Other: _____ | | |

Head, Eyes, Ears, Nose and Throat

- | | | |
|---|---|--|
| <input type="radio"/> Bitter taste | <input type="radio"/> Grinding of teeth | <input type="radio"/> Ringing in ears |
| <input type="radio"/> Blurred vision | <input type="radio"/> Goiter | <input type="radio"/> High pitch |
| <input type="radio"/> Cataracts | <input type="radio"/> Gum problems | <input type="radio"/> Low pitch |
| <input type="radio"/> Concussions | <input type="radio"/> Headaches | <input type="radio"/> Sinus issues |
| <input type="radio"/> Dry mouth / nose | <input type="radio"/> Hearing aids | <input type="radio"/> Spots in eyes |
| <input type="radio"/> Ear aches | <input type="radio"/> Itchy eyes | <input type="radio"/> Swollen glands |
| <input type="radio"/> Excess phlegm | <input type="radio"/> Migraines | <input type="radio"/> Teeth issues |
| <input type="radio"/> Eye pain or strain | <input type="radio"/> Nose bleeds | <input type="radio"/> TMJ Syndrome |
| <input type="radio"/> Facial pain | <input type="radio"/> Poor hearing | <input type="radio"/> Trigeminal neuralgia |
| <input type="radio"/> Glasses or contacts | <input type="radio"/> Red or dry eyes | <input type="radio"/> Watery eyes |
| <input type="radio"/> Glaucoma | | |
| <input type="radio"/> Other: _____ | | |

Respiratory:

- | | | |
|---------------------------------------|--------------------------------------|---|
| <input type="radio"/> Asthma/Wheezing | <input type="radio"/> Cough + Phlegm | <input type="radio"/> Cough + blood |
| <input type="radio"/> Frequent colds | <input type="radio"/> Emphysema | <input type="radio"/> Difficult breathing |
| <input type="radio"/> Allergies | <input type="radio"/> Heavy Chest | <input type="radio"/> Tight Chest |
| <input type="radio"/> Bronchitis | <input type="radio"/> Pneumonia | <input type="radio"/> Short of Breath |
| <input type="radio"/> Cough | <input type="radio"/> COPD | |
| <input type="radio"/> Other: _____ | | |

Cardiovascular:

- | | | |
|--|--|--|
| <input type="radio"/> Anemia | <input type="radio"/> Fainting | <input type="radio"/> High blood pressure |
| <input type="radio"/> Arteriosclerosis | <input type="radio"/> High cholesterol | <input type="radio"/> Irregular heart beat |
| <input type="radio"/> Easily bruised | <input type="radio"/> Low blood pressure | <input type="radio"/> Pace maker |
| <input type="radio"/> Poor circulation | <input type="radio"/> Palpitations | <input type="radio"/> Phlebitis |
| <input type="radio"/> Blood clots | <input type="radio"/> Chest pain | <input type="radio"/> Stroke |
| <input type="radio"/> Heart Disease: _____ | | |
| <input type="radio"/> Other: _____ | | |

Gastrointestinal

- | | | |
|--|---|---|
| <input type="radio"/> # Bowel Movements/day ____ | | |
| <input type="radio"/> Normal Stool | <input type="radio"/> Pain after BM | <input type="radio"/> Bad breath |
| <input type="radio"/> Loose stool | <input type="radio"/> Heartburn/acid reflux | <input type="radio"/> Rectal pain/itching |
| <input type="radio"/> Constipation | <input type="radio"/> Abdominal pain | <input type="radio"/> Hemorrhoids |
| <input type="radio"/> Diarrhea | <input type="radio"/> Appendicitis | <input type="radio"/> Hernia |
| <input type="radio"/> Undigested food in stool | <input type="radio"/> Bloating | <input type="radio"/> Liver Disorder |
| <input type="radio"/> Mucous in stool | <input type="radio"/> Celiac Disease | <input type="radio"/> Ulcer |
| <input type="radio"/> Blood in stool | <input type="radio"/> Gas | <input type="radio"/> H. Pylori Negative |
| <input type="radio"/> Strong odour | <input type="radio"/> Hiccups | <input type="radio"/> H. Pylori Positive |
| <input type="radio"/> Pain before BM | <input type="radio"/> Nausea/vomiting | <input type="radio"/> Not Tested |
| <input type="radio"/> Other: _____ | | |

Genito-Urinary

- | | | |
|--|--|---|
| <input type="radio"/> Bed wetting | <input type="radio"/> Urgent urination | <input type="radio"/> Libido issues |
| <input type="radio"/> Bladder infections | <input type="radio"/> Wake to urinate | <input type="radio"/> Yeast infection |
| <input type="radio"/> Bloody urine | <input type="radio"/> Pale urine | <input type="radio"/> Impotence |
| <input type="radio"/> Frequent urination | <input type="radio"/> Dark urine | <input type="radio"/> Prostate Disorder |
| <input type="radio"/> Painful urination | <input type="radio"/> Cloudy urine | <input type="radio"/> Premature ejaculation |
| <input type="radio"/> Incomplete urination | <input type="radio"/> Kidney stones | <input type="radio"/> Nocturnal emissions |
| <input type="radio"/> Incontinence | <input type="radio"/> Kidney Disease | |
| <input type="radio"/> Other: _____ | | |

Gynecological

- | | | |
|--|---|--|
| <input type="radio"/> Menopause | <input type="radio"/> Genital discharge | <input type="radio"/> PMS – headaches |
| <input type="radio"/> Oral Birth control pills | <input type="radio"/> Genital swelling | <input type="radio"/> PMS – back aches |
| <input type="radio"/> Intra-Uterine Device IUD | <input type="radio"/> Hysterectomy | <input type="radio"/> PMS – mood swings |
| <input type="radio"/> Breast lumps | <input type="radio"/> Endometriosis | <input type="radio"/> # Pregnancies _____ |
| <input type="radio"/> Genital burning | <input type="radio"/> Fibroids | <input type="radio"/> # Miscarriages _____ |
| <input type="radio"/> Genital itching | <input type="radio"/> Cysts | |

Menstruation Information:

- Heavy periods
- Light periods
- Irregular periods
- Pain Before
- Pain During

Describe the menstrual blood:

- Pain After
- Dark Red
- Bright Red
- Pale Red
- Brownish

- Thin/Watery
- Very thick
- Clots?
 - Size _____
 - Color _____

Days between periods _____ # days of period _____

Other Information: _____

Skin and Hair

- | | | |
|--------------------------------------|---|--------------------------------------|
| <input type="radio"/> Acne | <input type="radio"/> Fungal infection | <input type="radio"/> Itchy/dry skin |
| <input type="radio"/> Burning skin | <input type="radio"/> Hair loss | <input type="radio"/> Psoriasis |
| <input type="radio"/> Dandruff | <input type="radio"/> Hot flashes | <input type="radio"/> Rashes |
| <input type="radio"/> Dermatitis | <input type="radio"/> Heavy sweating | <input type="radio"/> Shingles |
| <input type="radio"/> Discolorations | <input type="radio"/> Not able to sweat | <input type="radio"/> Warts |
| <input type="radio"/> Eczema | <input type="radio"/> Hives | |
| <input type="radio"/> Other: _____ | | |

Neuro-Psychological

- | | | |
|---------------------------------------|---------------------------------------|---|
| <input type="radio"/> ADD/ADHD | <input type="radio"/> Epilepsy | <input type="radio"/> Poor coordination |
| <input type="radio"/> Addiction | <input type="radio"/> Irritability | <input type="radio"/> Parkinson's Disease |
| <input type="radio"/> Anxiety | <input type="radio"/> Mental illness | <input type="radio"/> Poor memory |
| <input type="radio"/> Depression | <input type="radio"/> numbness | <input type="radio"/> Seizure |
| <input type="radio"/> Easily stressed | <input type="radio"/> "Foggy" feeling | <input type="radio"/> Vertigo/Dizziness |
| <input type="radio"/> Other: _____ | | |

Musculoskeletal:

- | | | |
|--|--------------------------------------|-----------------------------------|
| <input type="radio"/> Osteoarthritis | <input type="radio"/> Limited motion | <input type="radio"/> Neck pain |
| <input type="radio"/> Rheumatoid arthritis | <input type="radio"/> Limited use | <input type="radio"/> Rib pain |
| <input type="radio"/> Atrophy | <input type="radio"/> Back pain | <input type="radio"/> Scoliosis |
| <input type="radio"/> Body heaviness | <input type="radio"/> Muscle pain | <input type="radio"/> Weight gain |
| <input type="radio"/> Joint pain | <input type="radio"/> Muscle cramps | <input type="radio"/> Weight loss |
| <input type="radio"/> Broken Bones: _____ | | |
| <input type="radio"/> Other: _____ | | |