Acupuncture specific Intake Form

Patient Name:__________________________________Date: ________________File#________________

Habits:
Do you have a regular exercise program? Please describe.

Please indicate usage per day or per week:
Water ______ ounces per day
Coffee ______ ounces per day
Tea ______ day/week (circle)
Alcohol ______ day/week Type liquor/beer/wine
Soft Drinks ______ day/week
Cigarettes ______ day/week
Sweets ______ day/week

Energy:
How is your energy? (Please circle). Low 1 2 3 4 5 6 7 8 9 10 high
What time of day is your energy (Please circle):
Highest: 6am-12pm/1pm-5pm/6pm-12am
Lowest: 6am-12pm/1pm-5pm/6pm-12am
Do you fatigue easily? Yes/ No

Stress & Sleep:
How do you handle stress?
How do you relax?
How do you feel about your work?
How long do you normally sleep? _________hours per night

I have difficulties with (circle all that apply):

Falling asleep	Staying asleep	Dream-disturbed sleep

Waking up at about _____am/pm and not being able to fall asleep again

Review of Systems: Please circle if you have had (in the last 3 months) any of the following conditions.

General:

Poor Appetite	Fatigue	Bleed/bruise easily	Cravings
Poor Sleeping	Fevers	Sudden energy drop	Weight gain
Poor balance	Chills	Strong thirst	Weight loss
Pain	Night Sweats	Peculiar tastes	Desire hot food
Localized weakness	Sweat easily	Change in appetite	Desire cold food

Skin & Hair:

Rashes	Ulcerations	Hives	Itching
Eczema	Acne	Dandruff	Dry Skin
Recent Moles	Hair Loss	Change in skin/hair texture	

Musculoskeleteal:

Joint Injury	Muscle Weakness	Hip pain	Hands/feet Swelling
Arthritis	Tingling	Knee Pain	Cold hands/feet

Difficulty Walking	Paralysis	Ankle pain/Weakness	Back Pain
Tremors	Neck pain/tightness	Hand/Wrist Pain	Spinal Curvature
Numbness	Shoulder pain/tightness	Muscle Pain/Soreness	Hernia

Head, eyes, ears, nose, and throat:

Dizziness	Concussions	Headaches	Migraines
Eye Strain	Itching/Burning Eyes	Night Blindness	Poor Vision
Blurry Vision	Spots in front of eyes	Ringing in Ears	Poor Hearing
Sores on Lips/Tongue	Sinus problems	Nose Bleeding	Sore Throat
Grinding Teeth	Difficulty Swallowing	Facial Pain	Earache

Cardiovascular & Respiratory:

High Blood pressure	Chest pain	Palpitations	Faiting
Irregular heartbeat	Rapid heartbeat	Varicose veins	Dry cough
Productive cough	Coughing blood	Shortness of breath	Wheezing
Bronchitis	Pneumonia		

Neurological & Psychological:

Loss of balance	Loss of Memory	Lack of Coordination	Depression
Anxiety	Stress	Bad Temper	Bipolar
Panic attacks	Difficulty concentrating	Nervousness	

Gastrointestinal:

Nausea	Vomiting	Belching	Bad Breath
Gas	Indigestion	Abdominal pain/cramps	Loose Stools
Diarrhea	Constipation	Hemorrhoids	Gallbladder problems
Parasites	Chronic laxative use	Bowel Movement frequency: #______/day	Hernia

Genito-urinary:

Frequent urination	Painful urination	Urgent urination	Incontinence
Blood in urine	Genital pain	Genital itching	Genital discharge
Kidney stones	Frequent Urinary Tract infection	Pelvic Infection	Ovarian cysts
Frequent Vaginal infection	Prostate problems	Impotence	Excessively high/low libido

Menstrual & Birth History (Women only):
Are you currently pregnant? Y/N (circle)

Irregular periods	Painful periods	Breast tenderness	Breast Lumps
Endometriosis	Fibroids	Hot Flashes	Menopausal
Clots in menstrual blood	Moodiness related to periods	Age of first menses:____	Duration of periods: ______ Days
Use birth control? If yes what type and how long?	Number of pregnancies: #____ Number of Cesareans #____	Number of births: #_____ Number of premature births: #_____	Miscarriages: #____ Abortions: #___

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Patient Signature: ____ Signature date: _________________________

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