



Acupuncture Initial Intake

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Name: _____ Birthdate: _____
Date: ____/____/____ Age: _____

	Severe	Moderate	Slight	Major Complaint(s), in order of importance to you:
1.	—	—	—	_____
2.	—	—	—	_____
3.	—	—	—	_____
4.	—	—	—	_____
5.	—	—	—	_____

Have you received a diagnosis for you condition(s)? Y / N
If so, what diagnosis? _____
By whom? _____

When / how did these conditions occur? (provide dates if possible)

How do these conditions impair your daily activities?

Treatment(s) that you have received for these conditions?

What treatment(s) helped the most?

<u>Medical conditions</u>		<u>Allergies</u>	<u>Occupational Concerns</u>	<u>Diet and Exercise</u>
Please List conditions & surgeries you have had and year diagnosed.		Medications, Seasonal, Environmental, Food.	Check (✓) if your work exposes you to the following:	Check (✓) all that apply:
Year	Surgery/Hospitalization/Accidents Trauma (Physical and Emotional)		<input type="checkbox"/> Stress	<input type="checkbox"/> Regular Exercise
			<input type="checkbox"/> Environmental	<input type="checkbox"/> Low-Fat
			<input type="checkbox"/> Excessive Typing	<input type="checkbox"/> Low-Carb
			<input type="checkbox"/> Heavy Lifting	<input type="checkbox"/> Vegetarian
			<input type="checkbox"/> Others:	<input type="checkbox"/> Other
				<input type="checkbox"/> Drink Coffee
				Cup(s) per day _____
			Occupation:	<input type="checkbox"/> Drink Soda
				oz. per day _____

<u>Medications</u>					
Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

<u>Supplements</u>					
Name	Purpose	How Long	Dose	How Often	Last Dose

PAST MEDICAL HISTORY

Measles	no	yes	Hernia	no	yes
Hives or Eczema	no	yes	Thyroid Disease	no	yes
Mumps	no	yes	Blood Transfusions	no	yes
Tuberculosis	no	yes	Kidney Disease	no	yes
Infectious Mono	no	yes	AIDs or HIV+	no	yes
Chickenpox	no	yes	Heart Disease	no	yes
Diabetes	no	yes	Bleeding tendency	no	yes
Rheumatic Fever	no	yes	High Blood Pressure	no	yes
Whooping Cough	no	yes	High Cholesterol	no	yes
Cancer	no	yes	Anemia	no	yes
Mitral Valve Prolapse	no	yes	STD's	no	yes
Scarlet Fever	no	yes	Any other disease (please list)		
Polio	no	yes	_____		
Stroke	no	yes	_____		

FAMILY HISTORY:

	Who		Who
Alcohol or Drug Problem		HIV	
Allergies		Kidney Disease	
Anemia		Leukemia	
Ankylosing Spondylitis		Mental Illness	
Asthma		Migraine Headaches	
Autoimmune disorders		Multiple Sclerosis	
Cancer		Muscular Dystrophy	
Chronic Lung Disease		Obesity	
Diabetes		Osteoporosis	
Eczema		Psoriasis	
Epilepsy		Rheumatoid Arthritis	
Glaucoma		Stroke	
Gout		Thyroid Disease	
Heart Disease		Tuberculosis	
Hepatitis		Ulcers	
High Blood Pressure		Other	
High Cholesterol			

Symptoms—Note: For each symptom you currently have, rate it's severity from 1-5 (5 being the worst).

Leave blank if not applicable.

<p>Liver / Gallbladder</p> <p><input type="checkbox"/> Irritability / Anger</p> <p><input type="checkbox"/> Depression / Stress</p> <p><input type="checkbox"/> Headaches / Migraines</p> <p><input type="checkbox"/> Visual Problems</p> <p><input type="checkbox"/> Red / Dry / Itchy Eyes</p> <p><input type="checkbox"/> Gall Stones</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Blurred Vision</p> <p><input type="checkbox"/> Feeling of Lump in Throat</p> <p><input type="checkbox"/> Clenching of Teeth at Night</p> <p><input type="checkbox"/> Muscle Cramping</p> <p><input type="checkbox"/> Twitching</p> <p><input type="checkbox"/> Tension</p> <p><input type="checkbox"/> Joints/Neck/Shoulder Pain/Tight</p> <p><input type="checkbox"/> Poor Circulation</p> <p><input type="checkbox"/> Soft / Brittle Nails</p> <p><input type="checkbox"/> Emotional Eater</p> <p><input type="checkbox"/> Bad Taste Muscles</p> <p><input type="checkbox"/> Bad Breath</p> <p><input type="checkbox"/> Do you Crave: Sour</p> <p>Kidney / Urinary Bladder</p> <p><input type="checkbox"/> Urinary Problems</p> <p><input type="checkbox"/> Bladder Infection</p> <p><input type="checkbox"/> Dropped Bladder</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Lack of Bladder</p> <p><input type="checkbox"/> Weakness/ Pain in Lower Back</p> <p><input type="checkbox"/> Decrease Bone Density</p> <p><input type="checkbox"/> Feel Cold Easily</p> <p><input type="checkbox"/> Cold Hands</p> <p><input type="checkbox"/> Cold Feet Grief / Sadness</p>	<p><input type="checkbox"/> Low Sex Drive / Libido</p> <p><input type="checkbox"/> Excess Sexual Desire</p> <p><input type="checkbox"/> Poor Memory</p> <p><input type="checkbox"/> Loss of Hair</p> <p><input type="checkbox"/> Hearing Difficulties</p> <p><input type="checkbox"/> Excessive Cavities</p> <p><input type="checkbox"/> Fear</p> <p><input type="checkbox"/> Hot Flash / Night Sweats</p> <p><input type="checkbox"/> Do You Crave: Salty</p> <p>Heart / Small Intestine</p> <p><input type="checkbox"/> Heart Palpitations</p> <p><input type="checkbox"/> Insomnia / Sleep disturbances</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Easily Startled</p> <p><input type="checkbox"/> Restlessness / Agitation</p> <p><input type="checkbox"/> Vivid Dreams</p> <p><input type="checkbox"/> Do You Crave: Bitter</p> <p>Lung / Large Intestine</p> <p><input type="checkbox"/> Bloody Cough</p> <p><input type="checkbox"/> Dry Cough</p> <p><input type="checkbox"/> Cough with sputum</p> <p><input type="checkbox"/> Nasal discharge</p> <p><input type="checkbox"/> Post-nasal drip</p> <p><input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> Congestion</p> <p><input type="checkbox"/> Red, sore, itchy throat</p> <p><input type="checkbox"/> Dry mouth, throat, nose</p> <p><input type="checkbox"/> Skin rashes, hives</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Grief / Sadness</p> <p><input type="checkbox"/> Shortness of Breath</p>	<p><input type="checkbox"/> Allergies / Asthma</p> <p><input type="checkbox"/> Low resistance to colds / flu</p> <p><input type="checkbox"/> Sneezing</p> <p><input type="checkbox"/> Mild fever comes / goes</p> <p><input type="checkbox"/> Smoke cigarettes</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Black stools / blood in stool</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> IBS</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Spastic colon</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Do You Crave: Pungent</p> <p>Spleen / Stomach</p> <p><input type="checkbox"/> Heaviness anywhere in body</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Difficulty waking in morning</p> <p><input type="checkbox"/> Muscle fatigue</p> <p><input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Easily to bruise and bleed</p> <p><input type="checkbox"/> Bad Breath</p> <p><input type="checkbox"/> Nausea / Vomiting</p> <p><input type="checkbox"/> Gas / Belching</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Excessive Worry</p> <p><input type="checkbox"/> Brain Fog</p> <p><input type="checkbox"/> Tendency to gain weight</p> <p><input type="checkbox"/> Do You Crave: Sweet</p>
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ACUPUNCTURE CONSENT FORM

“Acupuncture” means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body.

Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations), cupping (whereby suction cups are applied to specific points on the body or motion suction cups).

The potential risks: Slight pain or discomfort at the site of needle insertion, infection (rare), bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.

I state that I do not have the following conditions:

- Pregnancy
- Bleeding disorders
- Pacemaker
- Local infections
- Use of Anticoagulants

If I do have any of the above conditions, I have listed them here: _____

The potential benefits: Acupuncture may allow for the painless relief of one’s symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

“With this knowledge, I voluntarily consent to the above procedures.”

Printed Name

Signature

Witness Signature

Date