Adult Intake - Acupuncture

Name: ____ Date:______________

Date of birth: ________________ Sex: M F

Address: ____
____
____
____

Email address: ____

Would you like to receive our email newsletter? Y N
(We will not share your email address with anyone else)

Phone number: Home: _____________________ Work/Cell: ____________________

Can we leave messages relating to your visits (eg: reminder calls)? Y N

Emergency contact: Name: ____

Relation: _____________________ Phone number: ____________________

How did you hear about the clinic? ____
____

Other health care providers you are seeing (ie. medical doctor, chiropractor, etc):

1. ____________________ 2. ____________________ 3. ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
(____)______________ (____)______________ (____)______________

Your reasons for seeking acupuncture/treatment goals:

1. ____

2. ____

3. ____

Have you had acupuncture before: Y N

If yes, please explain (what it was for, how was the experience)

____

Do needles bother you: Y N

If yes, please explain ____

Medical History:

Do you see a medical doctor regularly: Y N

Do you get regular blood work: Y N

Do you currently have or have you ever had any of the following: (please circle)

AIDS
Allergies
Anemia
Anxiety
Arthritis
Asthma
Bipolar disorder
Cancer
Chronic fatigue syndrome
Deep vein thrombosis
Depression
Diabetes
Digestive disorders

Drug addiction
Epilepsy
Fibromyalgia
Gall stones
HIV
Heart condition
Hemophilia
High/Low blood pressure
Jaw pain
Kidney disease/stones
Liver condition
Migraines
Multiple sclerosis

Osteoporosis
Pacemaker
Respiratory condition
Rheumatic fever
Sinus problems
Skin condition
Spinal injury
Sprains or fractures
Stroke
Thyroid problem
Tuberculosis
Ulcers
Ulcerative Colitis

Other (Please specify): ____

____

Please list all Medications, Herbs, Vitamins and Supplements:

____

____

____

____

List past injuries, hospitalizations or surgeries with approximate dates (unless already noted previously:

____
____
____
____
____
____

Do you have any allergies (medications, environmental, etc)?

____
____
____

Do you frequently use any of the following (please check yes or no):

	Yes	No	If yes, how often
Painkillers	____	____	________________________
Antacids	____	____	________________________
Laxatives	____	____	________________________
Birth control pills	____	____	________________________

	Yes	No	If yes, form and how often
Tobacco	____	____	________________________
Alcohol	____	____	________________________
Caffeine	____	____	________________________
Recreational drugs	____	____	________________________

Lifestyle:

Describe your diet: ____

Do you crave any particular foods: ____

Exercise: Y N If yes, describe _____________________________________

Stress level: Low - 1 2 3 4 5 6 7 8 9 10 - High

Physical symptoms when stressed: ____
____

Sleep: Hours per night: ___________ Rested in AM: ____________________

Trouble falling asleep: ___________ Trouble staying asleep: ____________

Occupation: _______________________________ Enjoy work: Y N

Hobbies: ____

Do you have children (if so what age): ____

Symptom Survey (please check all that apply):

0= Never 1= Rarely 2= Occasionally 3= Frequently 4= Always

0 1 2 3 4 low appetite
0 1 2 3 4 loose stools
0 1 2 3 4 gas/ abdominal bloating
0 1 2 3 4 fatigue after eating
0 1 2 3 4 hemorrhoids
0 1 2 3 4 bruise easily
0 1 2 3 4 anemia

0 1 2 3 4 ravenous appetite
0 1 2 3 4 heartburn/ acid reflux
0 1 2 3 4 mouth sores
0 1 2 3 4 belching or vomiting
0 1 2 3 4 gums bleeding/swollen
0 1 2 3 4 thirst Hot? Cold?
0 1 2 3 4 bad breath

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0 1 2 3 4 abnormal swelling
0 1 2 3 4 allergies
0 1 2 3 4 asthma
0 1 2 3 4 shortness of breath
0 1 2 3 4 cough
0 1 2 3 4 dry nose/mouth/skin/throat

0 1 2 3 4 fatigue
0 1 2 3 4 catch colds easily
0 1 2 3 4 tired after little exertion
0 1 2 3 4 general weakness
0 1 2 3 4 nasal discharge
0 1 2 3 4 sinus congestion

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0 1 2 3 4 sore, cold or weak knees
0 1 2 3 4 low back pain
0 1 2 3 4 frequent urination
0 1 2 3 4 urinary incontinence
0 1 2 3 4 ear/hearing problems
0 1 2 3 4 early morning diarrhea

0 1 2 3 4 feel cold often
0 1 2 3 4 swollen ankles
0 1 2 3 4 poor memory
0 1 2 3 4 hair loss
0 1 2 3 4 infertility
Low Normal High libido

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0 1 2 3 4 irritable
0 1 2 3 4 ligament/tendon issues
0 1 2 3 4 tight feeling in chest
0 1 2 3 4 alternate diarrhea/constipation
0 1 2 3 4 sigh frequently
0 1 2 3 4 neck/shoulder tension

0 1 2 3 4 muscle spasms/twiches
0 1 2 3 4 numb extremities
0 1 2 3 4 dry, irritated eyes
0 1 2 3 4 ear ringing
0 1 2 3 4 anger easily
0 1 2 3 4 red eyes

0= Never 1= Rarely 2= Occasionally 3= Frequently 4= Always

0 1 2 3 4 feel heart beating
0 1 2 3 4 insomnia
0 1 2 3 4 sores on tip of tongue
0 1 2 3 4 anxiety
0 1 2 3 4 chest pain
0 1 2 3 4 disturbing dreams
0 1 2 3 4 restlessness
0 1 2 3 4 palpitations

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0 1 2 3 4 dizzy upon standing
0 1 2 3 4 floaters in eyes
0 1 2 3 4 heat in palms or soles
0 1 2 3 4 afternoon fever
0 1 2 3 4 night sweats
0 1 2 3 4 flushed face
0 1 2 3 4 feeling of heaviness
0 1 2 3 4 nausea
0 1 2 3 4 foggy thinking
0 1 2 3 4 enlarged lymph nodes
0 1 2 3 4 cloudy urine

Urination: Circle all that apply: Burning Urgent Scanty Difficult
Profuse Dribbling More than 1 time a night

Bowel movements: Frequency _____________
Consistency (circle): Well-formed Hard Loose Alternates
Do you ever have (circle): Undigested food Blood Mucous

Do you prefer beverages that are: Warm Cold Room temperature
Do you find that you tend to be particularly hot or cold: __________________________________
How is your energy level in general: ____

Women Only:
Are you currently pregnant: Y N Unsure
# of pregnancies ______ # of live births _______ # of miscarriages ______
How old were you when you had your first period: ____________
Have you experienced menopause: Y N When? _________________

Are you experiencing perimenopausal symptoms, please describe: ________________________

____

Vaginal discharge: Y N Clear/White/Yellow/Green Itch/Burn/Pain/Foul Odor

Is your period regular:__________ When was the first day of your last period: _____________

Length of cycle (start of one period to start of the next): ________

Average number of days of flow: _________ Flow: Light Normal Heavy

Colour (circle all that apply): Pale Normal Dark Bright Red Brown Purple

Blood clots: Y N

Cramps: Y N Severe: Y N

Type of pain: Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your period:

Breast Swelling/tenderness Water retention Depression Irritability Headaches

Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

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Men Only:

Circle all that apply:

Groin pain	Enlarged prostate	Decreased libido	Testicular pain
Impotence	Painful urination	Difficult urination	Premature ejaculation
Nocturnal emissions		Increased libido	