Adult Intake - Acupuncture

Name: _____ Date:_____

Date of birth: _____ Gender: 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: _____ Cell: _____
Work: _____

Would you like to receive confirmation emails when you schedule/change appointments?
Yes No

Our office will send appointment reminders 48 hrs prior to your appointment, **you must opt for at least 1:**

- ☐ Phone call- preferred phone to contact: _____
- ☐ Email
- ☐ Text message

Optional additional reminders (we can send you as many as you like):

- ☐ Email 24 hours before
- ☐ Email 3 hours before
- ☐ Text message 24 hours before
- ☐ Text message 3 hours before
- ☐ Phone call 24 hours before

Insurance Provider

Primary: _____ Secondary: _____

- ☐ I prefer to bill my own insurance
- ☐ I prefer the clinic to bill my insurance on my behalf

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

Please list all Medications, Herbs, Vitamins and Supplements:
_____
_____
_____
_____

List past injuries, hospitalizations or surgeries with approximate dates:
_____
_____
_____
_____
_____
_____

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

AIDS	Drug addiction	Osteoporosis
Allergies	Epilepsy	Pacemaker
Anemia	Fibromyalgia	Respiratory condition
Anxiety	Gall stones	Rheumatic fever
Arthritis	HIV	Sinus problems
Asthma	Heart condition	Skin condition
Bipolar disorder	Hemophilia	Spinal injury
Cancer	High/Low blood pressure	Sprains or fractures
Chronic fatigue syndrome	Jaw pain	Stroke
Deep vein thrombosis	Kidney disease/stones	Thyroid problem
Depression	Liver condition	Tuberculosis
Diabetes	Migraines	Ulcers
Digestive disorders	Multiple sclerosis	Ulcerative Colitis

Other (Please specify): _____

_____

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 ravenous appetite
0 1 2 3 4 loose stools	0 1 2 3 4 heartburn/ acid reflux
0 1 2 3 4 gas/ abdominal bloating	0 1 2 3 4 mouth sores
0 1 2 3 4 fatigue after eating	0 1 2 3 4 belching or vomiting
0 1 2 3 4 hemorrhoids	0 1 2 3 4 gums bleeding/swollen
0 1 2 3 4 bruise easily	0 1 2 3 4 thirst Hot? Cold?
0 1 2 3 4 anemia	0 1 2 3 4 bad breath

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0 1 2 3 4 abnormal swelling	0 1 2 3 4 fatigue
0 1 2 3 4 allergies	0 1 2 3 4 catch colds easily
0 1 2 3 4 asthma	0 1 2 3 4 tired after little exertion
0 1 2 3 4 shortness of breath	0 1 2 3 4 general weakness
0 1 2 3 4 cough	0 1 2 3 4 nasal discharge
0 1 2 3 4 dry nose/mouth/skin/throat	0 1 2 3 4 sinus congestion

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

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

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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	