



ACUPUNCTURE BODYWORK

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Patient Intake Form

Note: Information provided on this form is confidential. Today's Date _____
It is very important the information given is complete and accurate to assist you properly in your healing process

PERSONAL INFORMATION - PLEASE PRINT

How did you hear about us? _____

Name _____ Date of Birth _____

Age _____ Gender _____ Marital Status _____

Occupation _____

Address _____

City/State/Zip _____

Phone # (W) _____ (H) _____ (Cell) _____

Email Address _____

Mailing Address _____

Name and phone number of the emergency contact person _____

Primary physician's name, phone #, and address _____

What do you want treated with acupuncture? _____

How long have you had this condition? _____ The onset was sudden gradual

Symptoms relieved by: _____ Symptoms worsened by: _____

Are you taking any medications? _____

For what condition(s) _____

Is this your first experience in Oriental Medicine and acupuncture? _____

Are you currently pregnant? Yes No

Are you currently trying to get pregnant? Yes No

How do you feel about acupuncture? _____

PAST MEDICAL HISTORY

Have you had or have any of these conditions (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies (food, latex) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Addictions | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis A/B/C |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Joint Replacements | <input type="checkbox"/> Lyme's Disease |
| <input type="checkbox"/> Lymph Nodes removed | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Frequent use of antibiotics | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Illnesses, accidents or injuries | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Other |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Operations | <input type="checkbox"/> Vaccinations |

FAMILY MEDICAL HISTORY

(Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Exercise and Energy:

How is your energy? _____

What time of day is your energy: Highest? _____ Lowest? _____

Do you fatigue easily? _____

What kind of exercise do you do? _____

How often do you exercise? _____

Emotions and Sleep:

How do you feel emotionally? _____

I have or often have (Please check all that apply)

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Fear Attacks |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Difficult-concentration | <input type="checkbox"/> Insomnia |

Are you in a relationship? Yes No

How do you feel about your relationship? _____

How do you hold stress? _____

How do you relax? _____

How do you feel about your relationship? _____

Eyes, Ears, Nose & Throat:

Do you smoke? Yes No _____ per day, for year(s) _____

I have or often have (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Chronic runny nose | <input type="checkbox"/> Frequent sore throat |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Cough up mucous |
| <input type="checkbox"/> Pain inhaling | <input type="checkbox"/> Shortness of breath on exertion/at rest | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Painful/red eyes | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> See spots/floaters | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Ear Pain |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Clogged/popping in ears | <input type="checkbox"/> Other |

Describe: _____

Frequent headaches/migraines Describe: _____

Cardiovascular:

I have (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitation | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Other Describe: _____ | |

Skin & Hair:

I have or often have (Please check all that apply)

- | | | |
|------------------------------------|---|----------------------------------|
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Pre-mature graying | <input type="checkbox"/> Other |

Describe: _____

Muscles, Joints & Bones:

Do you have pain or tightness? Yes No Where? _____

The pain is (Please check all that apply)

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Pain worse/better with cold | <input type="checkbox"/> Superficial pain | <input type="checkbox"/> Deep pain |
| <input type="checkbox"/> Pain worse/better with pressure | <input type="checkbox"/> Tingling | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Pain worse/better with heat | <input type="checkbox"/> Numb | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Pain worse in am/pm | <input type="checkbox"/> Other | |

Describe: _____

I have (Please check all that apply)

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Arthritis/joint pain | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Bone pain | <input type="checkbox"/> Muscle cramping | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Repetitive Strain Injury | <input type="checkbox"/> Fractured Bone(s) | |

Where? _____

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE:

0 _____ 10
(no pain) (severe pain)

**PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATION
ON THE BODY MAP BELOW:**

XXX = Pain

000 = Numb/Tingle

*** * * = Weakness**

