INTEGRATIVE ACUPUNCTURE

Initial Intake Form

Today's Date _____/_____/_____

Thank you for taking the time to complete the following information which will help us assess your health needs.
All information is confidential. We will be happy to answer any questions.

General Information

Name _____ Birthdate _____/_____/_____ Age _____ Gender _____

Address _____ City _____ State_____ Zip_____

Phone Numbers (please mark * next to best number)

Home _____ Cell_____ Work_____

Do you accept text messages? ☐ Yes ☐ No

Email _____

Would you like to receive our e-newsletter with supportive health information (only once per season)? ☐ Yes ☐ No

How did you hear about us? _____

May we send a thank you card? ☐ Yes ☐ No

Emergency Contact

Name _____ Phone _____ Relationship _____

Under 18 - Responsible Party Information

Name _____ Relationship to patient _____

Healthcare Providers - Please list those you work with

Physicians: GP/Primary Care: _____ seeking one? ☐ Yes ☐ No

OB-GYN: _____ seeking one? ☐ Yes ☐ No

Specialist (describe): _____ seeking one? ☐ Yes ☐ No

Chiropractor: _____ seeking one? ☐ Yes ☐ No

Massage Therapist: _____ seeking one? ☐ Yes ☐ No

Physical Therapist: _____ seeking one? ☐ Yes ☐ No

Psychotherapist: _____ seeking one? ☐ Yes ☐ No

Personal Trainer: _____ seeking one? ☐ Yes ☐ No

Midwife: _____ seeking one? ☐ Yes ☐ No

Other: _____ seeking one? ☐ Yes ☐ No

May we contact these providers to ensure coordination of your care? ☐ Yes ☐ No

Previous experience with acupuncture? ☐ Yes ☐ No With whom & results: _____

Lifestyle Habits

Describe your typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Special Diet: _____

3 worst foods you eat: _____

Do you:	Yes	No	
Average 6-8 hours sleep?			What is the major source of joy in your life?
Enjoy your work?			
Take vacations?			What is the major source of stress in your life?
Spend time outside?			
Exercise?			Describe exercise:
Watch TV?			How many hours weekly
Read Books?			How many hours weekly
Computer games/browsing?			How many hours weekly
Spiritual/religious practice?			Describe:
Smoke cigarettes?			How much?
Smoke cigarettes in the past?			How many years? How many packs?
Eat out often?			How many meals a week?
Drink coffee?			How many cups a day?
Drink tea?			How many cups a day?
Drink soft drinks?			How many a day?
Use sugar?			How much?
Drink alcohol?			How many drinks a week?
Use recreational drugs?			What and how often?
Have an addiction?			To what and how long?
Been outside the U.S. in past 12 months?			Where?

What are your goals for your health? _____

_____

_____

_____

Please circle your level of commitment to correcting your health issues? (10 = highest level)

1 2 3 4 5 6 7 8 9 10

Please mark the appropriate squares in the following list of symptoms.
If you have **had a symptom in the PAST** and do not have it now, check the box like this: ☑
If you are **having the symptom CURRENTLY**, fill in the box like this: ■

Liver/Gallbladder

☐ Depression / Stress
☐ Headaches / Migraines
☐ Red / Dry / Itchy Eyes
☐ Visual Problems / Blurred Vision
☐ Dizziness
☐ Gall Stones
☐ Feeling of Lump in Throat
☐ Clenching Teeth at Night
☐ Muscle Cramping / Twitching
☐ Neck/Shoulder Pain / Tightness
☐ Seizures/Tremors
☐ Poor Circulation
☐ Soft/Brittle Nails
☐ Bitter Taste in Mouth
☐ PMS/Menstrual Problems
☐ Tendonitis
☐ Pain Below Ribcage
☐ Do you crave: Sour
☐ Tend to be Irritable / Angry

Heart/Small Intestine

☐ Heart Palpitations
☐ Rapid or Irregular Heartbeat
☐ Chest Pain
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Insomnia / Sleep Problems
☐ Vivid Dreams / Nightmares
☐ Easily Startled
☐ Dark Urine
☐ Red Complexion
☐ Do you crave: Bitter
☐ Anxiety / Nervous or Restless

Spleen/Stomach

☐ Body Heaviness
☐ Hard to get up in Morning
☐ Muscles Often Feel Tired
___ Energy Level: 1-10 (low to high)
☐ Edema (☐ Hands ☐ Feet)
☐ Easily Bruising / Bleeding
☐ Bad Breath
☐ Sweetish Taste in Mouth
☐ Lack of Taste
☐ Excess or Low Appetite (circle which)
☐ Excess or Lack of Thirst (circle which)
☐ Nausea / Vomiting
☐ Gas / Belching
☐ Hemorrhoids
☐ Organ Prolapse (i.e. uterus)
☐ Chronic Loose Stools
☐ Abdominal Pain
☐ Indigestion / Heartburn
☐ Brain Foggy
☐ Mouth Ulcers
☐ Tendency to Gain Weight
☐ Do you crave: Sweet
☐ Over-thinking / Worry

Lung/Large Intestine

☐ Bloody Cough
☐ Dry Cough
☐ Chronic Cough
☐ Cough with Sputum
☐ Nasal Discharge
☐ White ☐ Yellow ☐ Green
☐ Post Nasal Drip
☐ Sinus Infection / Congestion
☐ Itchy, Red, or Painful Throat
☐ Dry Mouth / Nose / Throat
☐ Skin Rashes / Hives
☐ Snoring
☐ Shortness of Breath
☐ Allergies / Asthma
☐ Low Immunity
☐ Catch Colds Easily
☐ Bronchitis
☐ Black or Bloody Stools
☐ Constipation
☐ IBS
☐ Diarrhea
☐ Colitis / Spastic Colon
☐ Do you crave: Pungent / Spicy
☐ Grief / Sadness

Kidney/Urinary Bladder

☐ Urinary Problems (i.e. night-time) _____
☐ Bladder Infection
☐ Incontinence
☐ Weakness / Pain in Low Back
☐ Osteoporosis
☐ Feel Cold or Hot Easily (circle which)
☐ Cold Hands / Feet
☐ Low or Excess Sex Drive (circle which)
☐ Dark Circles under Eyes
☐ Thyroid Problems _____
☐ Poor Memory
☐ Hair Loss / Grey Hair
☐ Hearing Problems / Tinnitus
☐ Cavities
☐ Hot Flashes / Night Sweats
☐ Impotence or Premature Ejaculation (circle which)
☐ Do you crave: Salt
☐ Fear

Health History

Please list your major health concerns in order of importance to you: _____

_____

_____

_____

Check those that apply to your past medical history:

- ☐ Adverse reaction to medical treatment
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis or rheumatism
- ☐ Asthma
- ☐ Attempted suicide
- ☐ Birth trauma
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis/Liver disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Immune disorder
- ☐ Joint replacement
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Lyme's disease
- ☐ Lymph nodes removed
- ☐ Mental illness
- ☐ Multiple sclerosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Scarlet fever
- ☐ Seizures/Epilepsy
- ☐ Sinus infections
- ☐ Skin disease
- ☐ Special diet
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal disease/STD
- ☐ Other: _____

_____

List any serious diseases, injuries, surgeries or hospitalizations you have had and the year they occured: _____

_____

_____

_____

Medications, Herbs, Supplements (list those you are currently taking):

Name _____ Reason _____ How long, and dose _____

Name _____ Reason _____ How long, and dose _____

Name _____ Reason _____ How long, and dose _____

Name _____ Reason _____ How long, and dose _____

Name _____ Reason _____ How long, and dose _____

Name _____ Reason _____ How long, and dose _____