Patient Intake Form

Tx#:_____

Name: _____ DOB:_____/_____/_____ Date: _____/_____/_____

Age:_____ Sex: __ M __ F Height: _____ Weight: _____

Phone Number:_____ Email Address: _____

Address: _____ Zip Code: _____

Have you received acupuncture in the past? Yes __ No __

Describe your current problem and how it began:

_____

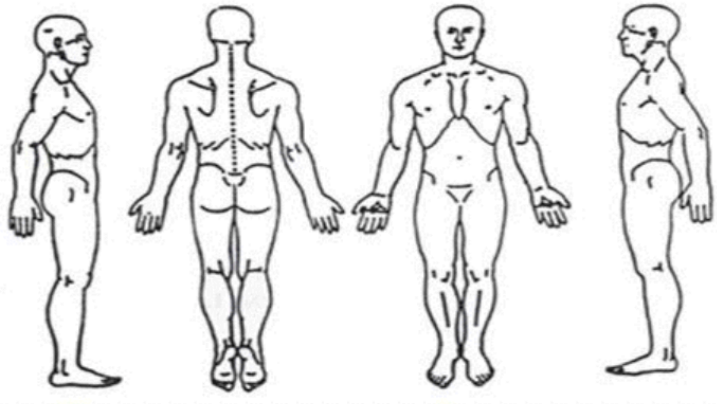
_____

_____

_____

_____

Please Circle Areas of Concern



Check Severity from a scale of 1(little) to 10(unbearale)

__1__2__3__4__5__6__7__8__9__10

Any other concerns that acupuncture may fix? _____

_____

Describe the quality of the following as best as possible:

Your Appetite: _____

Your Digestion: _____

Stool (daily?): _____

Urination (frequency?, quality, at night?): _____

Feel (Hot/Cold?): _____

Exercise & Energy: _____

Sweat (daytime? night?): _____

Thirst (unquenchable?): _____

Sleep?: _____

Emotions (tend to anger, sadness, joy, fear, or pensive?): _____

Menses (frequency? days? quality?): _____

Other: _____

MEDICATIONS: _____

SUPPLEMENTS: _____

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PLEASE CHECK OR CIRCLE THE SYMPTOMS YOU MAY BE EXPERIENCING AND INDICATE WHETHER YOU EXPERIENCE THESE SYMPTOMS OCCASIONALLY, OR CONSTANTLY

Irritability/Anger

Depression/Stress

Headache/Migraines

Visual Problems

Red/Dry/Itchy Eyes

Gallstones

Dizziness

Blurred Vision

Feeling of Lump in Throat

Clenching Teeth at Night

Muscle Cramps/Twitching/Tension

Joint/Neck/Shoulder Pain/Tightness

Poor Circulation

Soft/Brittle Nails

Emotional Eating

Urinary Problems

Lack of Bladder Control

Weakness/Pain in Low Back

Decreased Bone Density

Feeling Cold Easily

Low Sex Drive

Excessive Sexual Desire

Poor Memory

Loss of Hair

Hearing Problems

Cavities

Craving/Avoding Salty Food

Hot Flashes/Night Sweating

Heart Palpitations

Chest Pain

Insomnia/Sleep Problems

Easily Startled

Restlessness/Agitation

Vivid Dreams

Lack of Joy in Life

Dry Cough

Cough with Sputum

Nasal Discharge

Post Nasal Drip

Sinus Infection/Congestion

Itchy, Red or Painful Throat

Dry Mouth/Throat/Hives

Snoring

Grief/Sadness

Shortness of Breath

Allergies/Asthma

Low Resistance to Colds or Flu

Sneezing

Mild Fever Comes and Goes

Smoke Cigarettes

Cold (Entire Body)

Cold (Extremities)

Hot all Day

Hot in the Afternoon

Hot only at Night

Normal

Heaviness anywhere in the body

Fatigue worse after eating

Difficulty getting up in the AM

Edema (swelling)

Muscles often Feel Tired

Easy Bruising or Bleeding

Bad Breath

Decreased/Increased Appetite

Sweet Cravings

Hypoglycemia (low blood sugar)

Difficulty Digesting Oily Foods

Nausea/Vomiting

Gas/Belching

Insulin Sensitivity

Hemorrhoids

Constipation

Diarrhea

Abdominal Pain

Indigestion/Heartburn

Overthinking

Tendency towards Gain Weight

Brain Fog

Energy Level – Pease Circle:

1 –Low	6
2	7
3	8
4	9
5	10 - High