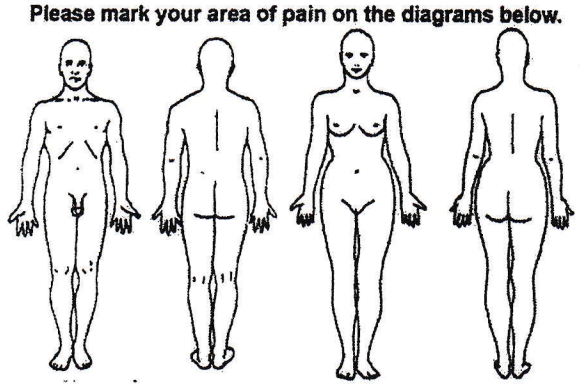
Acupuncture Form

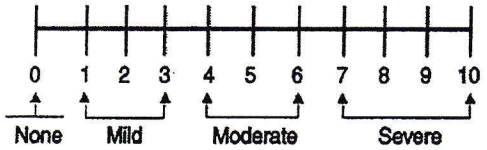
Patient Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Cell: _____ Work: _____
Date of Birth: _____ Age: _____ Email: _____
Marital Status: ☐M ☐ S ☐ W☐ D Occupation: _____
Emergency Contact's Name: _____ Phone: _____
Physician's Name: _____ Phone: _____
Height: _____ Weight: _____ Allergies: (**To Medications**): _____
Insurance Carrier: _____ Policy #: _____
Telephone number: _____ ☐ Insured ☐ Family member policy#: _____

1. Acupuncture before? ☐ Yes ☐ No Have you eaten today? ☐ Yes ☐ No : time of last meal? _____
2. **What is the problem that brought you here today?** _____
3. Was there a Physician's Diagnosis: _____
4. Has there been anything that has ever been able to change your problem in any way? ☐ Yes ☐ No
   a. If yes, please describe._____
5. When did this problem first appear? _____
6. Is it constant or does it come and go? _____
7. If applicable, does the problem ever move? (For example, pain or spasms that occur in different joints or muscles at different times) ☐ Yes ☐ No
8. Do you have a history of chronic pain? ☐ Yes ☐ No
9. Type of Pain: ☐Dull ☐Aching ☐Stabbing ☐Throbbing
10. Are you experiencing pain right now? ☐ Yes ☐ No
11. If yes, what number best describes your pain? _____

Please mark your area of pain on the diagrams below.



0-10 Pain Intensity Numeric Rating Scale (NRS)



12. What is the frequency of the pain? ☐ Continuous ☐ Intermittent
13. What makes your pain better? Please check all that apply: ☐Heat ☐Cold ☐Pressure ☐Rest ☐Movement ☐Massage ☐Other: _____
14. Is your illness affected by seasonal changes? Please describe._____
15. Are there other problems you would like addressed? _____
16. Have you had any surgeries? If yes, what type of surgery and when did you have it done?
_____
17. History of Significant Illness: **Self:** (Please include all past accidents, Childhood illnesses, and the date that they occurred, History of Vaccinations: Any reactions that you remember? Any unusual vaccinations?):
_____
_____
18. Do you have any infectious diseases? ☐ Yes ☐ No If Yes, Please List: _____

19.<u>General Health (pleases check all that apply)</u>: ☐Poor Appetite ☐Disturbed Sleep ☐Insomnia ☐Fatigue ☐Poor Coordination ☐Weight Gain ☐Cold Hands and Feet ☐Night Sweats ☐Cold Abdomen ☐Tremors ☐Large Appetite ☐Localized Weakness ☐Strong Thirst ☐Weight Loss ☐Fevers ☐Poor Balance ☐Bruise/Bleed Easily ☐Sweat Easily Cravings (explain below) ☐Chills ☐Sudden Energy Drop ☐Soft/Brittle Nails ☐Catch Colds Easily ☐Other (please specify): _____

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20.Skin and Hair (please check all that apply): ☐Rashes ☐Itching ☐Dandruff ☐Ulcerations ☐Redness ☐Eczema ☐Psoriasis ☐Hair Loss ☐Hives ☐Pimples ☐Recent Moles ☐Other (please specify)

_____

21.Head, Eyes, Ears, Nose, Throat (please check all that apply): ☐Dizziness ☐Eye Pain ☐Blurred Vision ☐Floaters ☐Spots in Eyes ☐Night Blindness ☐Ringing in Ears ☐Poor Hearing ☐Earaches ☐Headaches ☐Migraines ☐Recurrent Sore Throats ☐Sores on Lips orTongue ☐Dry Mouth/Throat ☐Bleeding Gums ☐Nosebleeds ☐Facial Pain ☐Jaw Clicking ☐Toothaches ☐Other (please specify) :

_____

22.Cardiovascular (please check all that apply): ☐Dizziness ☐Low Blood Pressure ☐High Blood Pressure ☐Irregular Blood pressure ☐Irregular Heart Beat ☐Fainting ☐Cold Hands/Feet ☐Chest Pain ☐Swelling of Hands/Feet ☐Blood Clots ☐Difficulty Breathing ☐Palpitations ☐Other (please specify) :

_____

23.Respiratory (please check all that apply): ☐Cough ☐Coughing Blood ☐Asthma ☐Bronchitis ☐Pneumonia ☐Coughing Phlegm ☐Pain with deep breath ☐Shortness of Breath ☐Nasal Congestion ☐Difficulty breathing when lying down ☐Other (please specify) : _____

24.Gastrointestinal/Abdominal issues (please check all that apply): ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Gas ☐Bloating ☐Belching ☐Abdominal Pain/Cramps ☐Indigestion ☐Heartburn/Reflux ☐Retention of Food in Stomach ☐Lack of Appetite ☐Excessive Appetite ☐Rectal Pain ☐Black Stools ☐Blood in Stool ☐Hemorrhoids ☐Bad Breath ☐Sensitive Abdomen ☐Chronic Laxative Use ☐Other (please specify):_____

25.Urinary and Genital (please check all that apply): ☐Pain on Urination ☐Frequent Urination ☐Blood in Urine ☐Urgency to Urinate ☐Unable to Hold Urine ☐Kidney Stones ☐Decrease in Urine Flow ☐Impotence ☐Sores on Genitals ☐Waking at Night to Urinate (how many times) ☐Other (please specify):

_____

26.Musculoskeletal (please check all that apply): ☐Neck Pain ☐Back Pain ☐Knee Pain ☐Muscle Pain ☐Foot/Ankle Pain ☐Shoulder Pain ☐Hip Pain ☐Hand/Wrist Pain ☐Sciatica ☐Muscle Weakness ☐Other Joint/Bone Problems (please specify): _____

27.Psychological and Neurological (please check all that apply): ☐Seizures ☐Dizziness ☐Loss of Balance ☐Areas of Numbness ☐Poor Memory ☐Lack of Coordination ☐Concussion ☐Depression ☐Anxiety ☐Bad Temper ☐Easily Stressed ☐Attempted Suicide ☐Emotional Problems ☐Other (please specify)

_____

28. Autoimmune and inflammatory conditions: ☐ hashimoto's disease (thyroid) ☐ rheumatism ☐ systemic lupus erthematosus ☐ colitis☐ crohn's ☐ alopecia (baldness) ☐ allergy ☐ food allergy ☐ atopic dermatitis ☐ neurodermatitis ☐ cellulitis ☐sinus allergy ☐ vulvitis ☐other: _____

29. Allergies: ☐ Yes ☐ No (Check Type: ☐Animal products/gelatin ☐ Citrus ☐Honey ☐Pollen ☐Fermented products ☐Shellfish☐ Soy ☐Talc ☐Wheat ☐Grass ☐Other (Please Describe): _____

30.Family Medical History: (check all which apply and specify which blood relative-father, mother, grandparents, brothers, or sisters): ☐Cancer (List below:type/family member) ☐High Blood Pressure ☐Hepatitis Rheumatic Fever ☐Infectious Disease ☐Diabetes ☐Heart Disease ☐Seizures ☐Emotional Disorder ☐Tuberculosis ☐Other (please specify)_____

31.Sleep: ☐Can't fall asleep, but once asleep stays asleep ☐Wakes easily☐tossing and turning, excessive dreaming/easily awakened, irritability ☐Grinds teeth in sleep ☐Restless sleep ☐Dream disturbed sleep ☐Sleep Apnea ☐Violent dreams ☐Dreamless sleep ☐After eating Lethargy or sleepiness ☐Fatigue after eating ☐Other sleep issues:

_____

Number of hours per night that you sleep:		Do you awake very early and are then unable to go back to sleep?	☐ *Yes* ☐ *No*
Do you have trouble	☐Yes ☐ No	Do you wake up frequently?	☐ *Yes* ☐ *No*

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falling to sleep?		If so when?	

32. Beverage intake/Smoking/Recreational: ☐Coffee ☐Black Tea ☐Caffeinated Beverages (☐Recreational Drug: ☐ Yes ☐ No) (☐Tobacco ☐ yes ☐ No ☐ Ever Smoked? ☐Yes☐ No If yes, when Quit: _____ a. If smoking, how many cigarettes do you smoke daily? _____ b. How many of packs do you smoke daily? _____ ☐Alcohol : ☐ yes ☐ No (Amount per day? _____ # per week? _____ ☐Exercise (please specify type, how often, and length of time):_____

33. Lifestyle: (rest, stress, emotions, tendencies, balance between work and play): Check all that apply: ☐Anxiety ☐Mania ☐Panic Attacks ☐Mood Swings ☐Depression ☐Seasonal Affective Disorder ☐Other:_____ _____

Hobbies? ☐Yes☐No ☐If No: Why? _____ (Type): _____

Do you feel you maintain a healthy balance between work and relaxation? ☐Yes☐No ☐If No, Explain:

_____

Travel: Places visited within the past year: (any out of country travel)? _____

Working environment: ☐Good ☐. Bad Explain:_____

Living Conditions: (Home situation): _☐Good ☐. Bad Explain: _____

34. (Female): Gynecological (please fill in where necessary): If Applicable:

Are you Pregnant: ☐Yes ☐No **Trying to conceive:** ☐Yes ☐No **Problems with conception:** ☐Yes ☐No

Age of 1st Period _____ Age at menopause _____ # of Pregnancies _____ #of Live Births _____

# of Premature Births _____ # of Miscarriages/Abortions _____ # of days between periods _____

# of days of flow _____ Color of blood: (light/dark)/(thick or thin) ☐Clots: ☐ Yes☐ No (Color: _____)

☐Painful Menses ☐Irregular Menses ☐Premenstrual Symptoms ☐Strong Menstrual Odor

☐Vaginal Discharge ☐Vaginal Odor ☐Vaginal Dryness ☐Fibroids ☐Breast Lumps/Swellings

☐Endometriosis ☐Ovarian Cysts ☐Sexually Transmitted Disease ☐Urinary Tract Infection

☐Hot Flashes ☐Decreased Sex Drive ☐Other (please specify):_____

_____

35. (Male): Issues: (Reproductive issues, Sexual function) If Applicable: Please Explain: _____

_____

36. Do you have any scars? ☐Yes☐No (Note location of all operation or injury scars, even minor ones below):

_____

_____

Any additional comments/concerns not covered listed in the above intake:

The information that I have documented on this form is accurate and I will advise the practitioner of any changes in my health or changes in my medications, nutritional supplements and dietary habits.

Signature of Patient: _____ **Date:** _____

Signature of Practitioner: _____ **Date:** _____