***Acupuncture Intake Form***

***Personal Information***

Patient Name:

Age: Birth Date:\_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:

Address:

City: State: Zip:

Telephone (Day):

Telephone (Night):

Telephone (Mobile):

Email Address:

Occupation:

Referral Source:

Who is your primary heath care provider/MD?

Emergency Contact: Phone:

***Main Complaint***

Please identify your major health concerns

1.

How long have you had this problem?

2.

How long have you had this problem?

3.

 How long have you had this problem?

 Have you been given a diagnosis for these problems?

 What other treatments have you tried and what were the outcomes?

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***Personal Medical History*** *(Please include your childhood history)*

Illnesses

Surgeries

Significant Trauma: (i.e. motor

vehicle accidents, fractures, etc.)

Do have a history of current or past

infectious disease? Please describe

Medicines (please list all

medications, herbs, vitamins and

over the counter drugs)

Allergies/Sensitivities (Please list any

foods, drugs, medications or

environmental factors which you are

sensitive or allergic to)

***General*** (please check all that apply)

 Poor Appetite

 Hearing Loss

 Easy to Bleed or Bruise

 Strong Thirst

 Puffiness or Swelling

 Night Sweats

 Changes in Appetite

***Skin & Hair***

 Rashes

 Skin Ulcers

 Hives

***Head, Eyes, Ears, Nose, and Throat***

 Dizziness

 Cataracts

 Taste/Smell Problems

 Eye Strain/Pain

 Nose Bleeds

 Migraines

 Recurrent Sore Throat

 Weakness

 Fevers

 Sweat Easily

 Poor Sleep

 Poor Balance

 Cravings

 Other:

 Itching

 Eczema

 Pimples

 Toothache

 Ear Ringing

 Headaches

 Night Blindness

 Facial Pain

 Ear Aches

 Lip or Tongue Sores

 Sudden Energy Drops

 Chills

 Fatigue

 Tremors

 Weight Loss

 Weight Gain

 Dandruff

 Hair Loss

 Recent Moles

 Blurry Vision

 Sinus Problems

 Concussions

 Poor Hearing

 TMJ Pain

 Spots in Front of Eyes

 Floaters

*patient signature: date:*

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