ACUPUNCTURE INTAKE FORM

Date: _____

Health Concerns

What is your chief complaint?	
How does this problem affect your daily activities?	
When did you first notice symptoms?	
If you have been diagnosed, what is the diagnosis?	
What kinds of treatment or therapies have you tried?	

List any Hospitalizations/Surgeries/Major Traumas	Date

List any allergies (drugs, chemicals, foods, environmental):			
List any medications, herbs, and supplements you currently take	Name	Dosage	Frequency

Medical History

Please check off the box(es) that apply to you

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Alcoholism			Diabetes			High cholesterol		
Arthritis			Digestive disorders			Seizures		
Anemia			Emotional disorders			Thyroid disease		
Breathing problems			Heart disease			Tuberculosis		
Cancer			Hepatitis			Other:		
Depression or anxiety			High blood pressure					

Please mark painful or distressed areas on the charts below

Symbol	Reaction
PAIN	
X	Little
XX	Moderate
XXX	Strong
SWELLING	
^	Slight
^^	Moderate
^^^	Severe
WEAKNESS/TEMP.	
~	Weak
+	Hot
SKIN PROBLEMS	
*	skin issue