ACUPUNCTURE INTAKE FORM

Date: _____

Patient General Information

First Name		Last Name					
Date of Birth		Occupation					
Email							
Address		City		State		Zip	
Home Phone		Cell phone					
Emergency Contact Name				Phone			
Recent Health Care (Provider/Date/Service Provided)							
Is this your first-time receiving acupuncture?							
Who may we thank for referring you?							

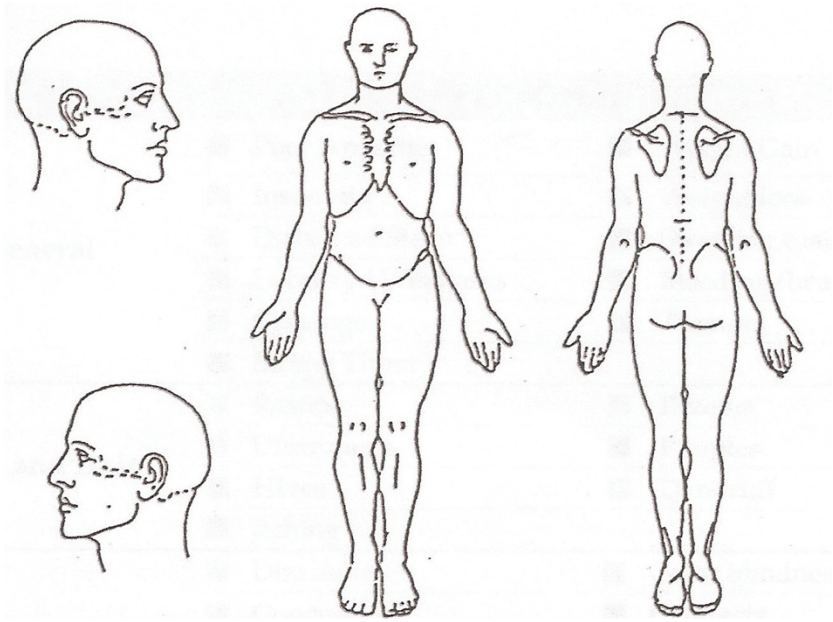
Health Concerns

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

Medical History

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