Friend Acupuncture Intake Form

Name:_____
Date:_____

Date of Birth:_____Age:_____

Gender: M / F/ Other Height:_____ Weight:_____

Address:_____City:_____State:___

zip: _____

Phone(home)_____(cell)_____

(work)_____

Which number would you prefer we use to contact you?

Home_____ Cell_____ Work_____ Text_____

Email:_____

Marital Status: S / M / D / W

Occupation:_____

Employer:_____

Name of Spouse/Partner:_____

Emergency contact name and number:_____

Medical Doctor and
Location:_____

Have you had previous Acupuncture Care? Y / N When:_____

Do you have any sensitivities/fears of needles? Y / N
Explain:_____

Do you have any sensitivities to massage lotions or oils? Y / N
Explain:_____ How did you hear about us?
_____

Chief Complaints:

1)

2)

3)

4)

5)

Are your present complaints due to an injury? Y____ N_____

Is your condition getting progressively worse? Y___ N____

Is your condition interfering with your: Work_____ Sleep_____ Daily Routine_____

Other_____

What makes your condition worse?

What makes your condition better?

Have you had this or a similar condition before? No_____

If yes explain:_____

Have you seen any other Physicians for this condition?
_____

List past diagnoses and treatments:

Have you been treated for any other health condition by a Physician in the past 5 years?
If Yes, Explain_____

HEALTH HISTORY:

List all current Prescription Medications:

Current non-prescription medications (laxatives, aspirin, antihistamines, decongestants, stimulants etc):_____
_____
_____

List all current Vitamins or Herbs:_____
_____

List any major accidents, serious falls or injuries (with dates):_____
_____
_____

List all previous Surgeries/ Hospitalizations:_____
_____
_____
_____

List all broken bones, cranial injuries:_____
_____
_____
_____

List x-rays or special imaging taken in the last 5 years, with reason and results:_____
_____
_____

Do/ Did you wear: Braces____ Glasses/contacts____ Mouth Guard_____ Retainer_____

Please CIRCLE all that you have or have had:

Alcoholism, Depression, Anemia, Diabetes, Appendicitis, Dyslexia, ADD/ADHD
Diverticulitis Osteoarthritis, Epilepsy, Cold sores/ Fever Blisters, Hepatitis, Colitis/ Bowel Disease, HIV Positive, Crohn's Disease, Influenza, Learning Disability
Lupus, Rheumatism, Polio, Migraine Headaches, Malaria, Scoliosis Measles, Stroke, Goiter, Celiac's Disease, Grave's Disease ,Cerebral Palsy, Hashimoto's Disease , Chronic Fatigue, Heart Disease, fibromyalgia, Tuberculosis, Typhoid Fever, Ulcers, Venereal DiseaseWhooping Cough, Rheumatoid Arthritis, Psoriasis

Other:_____

Family History, circle and explain which family member had the condition:

Cancer:

Heart Disease:

High Blood Pressure:

FEMALE ONLY:

Do you experience during menstruation (Circle):

Clots, Cramps, Dryness, Excessive Flow, Little flow, No Menstruation, Endometriosis, Fibroids, Hot flashes, PMS, Infertility, Irregular Cycle, Low Libido, Lumps in breasts, Night sweats, POCs, peri-menopause, Vaginal Discharge/ Color: _____, Yeast Infection,, Endometriosis

Are you pregnant at this time? Y___ N___ If yes, how far along? _____

What hospital are you delivering at? _____

Are you having any complications of pregnancy?_____

Are you trying to get pregnant?_____, If yes, for how long?_____

Length of Menstrual Cycle:_____days, Number of Days it lasts: _____

When was your last period_____

Are you undergoing fertility treatments? **Y / N**

If yes, Are you currently taking any medication_____

Have you done a clomid challenge? _____ Results?_____

# of Miscarriages:_____

MALE ONLY:

Decreased Urine flow Increased Urine flow Increased Urinary Urgency Erectile difficulties Gynecomastia

Incontinence Infertility
Low Libido
Low Sperm Count Nocturnal Emissions

Penile pain/ swelling Premature ejaculation Prostate Problems STD

Unusual thinning of hair

Last Prostate Exam:_____

Lifestyle:

Do you Exercise? Yes____ No____ How many hours per week:_____hrs

What kinds of
Exercise:_____
_____

Do you have (or had) a Personal Trainer? Yes____ No____

Stress Level: Heavy____ Moderate____ Low____

Alcohol consumption: Drinks per week?_____

Do you/ or did you ever smoke? Yes____ No___
How long have you smoked?_____

How many cigarettes do you smoke per day?_____

How many hours do you sleep per night?_____hrs

Non-medical drug use (type and
frequency):_____
__

Do you have silver dental fillings? Yes____ No____ Have you had a root canal?
_____ if yes, when? _____

Diet:

How many meals do you have per day?_____

Do you cook? Yes____ No____
Are you a vegan / vegetarian? Yes____ No____

If Yes, why?_____

Do you follow a specific diet regimen (if Yes, please
explain):_____

Do you have any sensitivities to: Milk_____ Gluten_____ Soy____
Other_____

Do you regularly eat fast foods/ or eat out? Yes____ No____
Do you regularly eat processed (deli) meats? Yes____ No____
Do you buy antibiotic free, cage free meats? Yes____ No____
Do you regularly crave sweets? Yes____ No____

Do you regularly eat frozen meals? Yes____ No____

Do you buy your vegetables Organic? Yes____ No____

Do you drink tap water/ filtered water/ bottled water
Do you drink coffee, caffeinated / decaffeinated with: _____Milk (cows milk, soymilk, almond milk etc.)

black tea/ green tea/ herbal tea with: _____Milk (cows milk, soymilk, almond milk etc.)

Water:_____cups/day **Coffee:**_____cups/day

List a typical Breakfast:_____
_____

List a typical Lunch:_____
_____

List a typical Dinner:_____
_____

Tea:_____cups/day **Soda**:_____cups/day
Energy drinks:_____cups/day **Protein drinks/ shakes**:_____cups/day