ACUPUNCTURE INTAKE FORM

Confidential Information & Health History

Today's Date: _____

First Name: _____ M.I.: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____ - ____ - _____ Sex: Male Female

Please indicate which phone # is the preferred way to reach you: Home Cell Work

Home: (___)_____ Cell : (___)_____ Work: (___)_____

Email: _____

Occupation: _____

Emergency Contact: _____ Phone: (___)_____

Relationship: _____ Referred By: _____

If not referred, how did you hear about us: _____

Is this your first time having acupuncture? _____ If no, how frequently do you get treatments? _____

What are your primary concern(s) that you would like to address?

_____

_____

When did you first notice these problems?

_____

Describe what activities aggravate or trigger these problems, if applicable:

_____

Please rate your pain/discomfort: (Low) 0 1 2 3 4 5 6 7 8 9 10 (High)

Please list any medications (vitamins, herbs or pharmaceutical) taken now or at regular intervals:

_____

_____

_____

√ Please check any of the following conditions below that currently affect you, or that you have experienced in the last year:

MUSCULOSKELETAL

__ Hip/Leg Pain
__ Arm Pain / Shoulder Pain
__ Low Back Pain
__ Mid Back Pain
__ Fibromyalgia
__ Spasms/Cramps
__ Sprains/Strains _____
__ Osteoporosis
__ Postural Deviations
__ Gout
__ Osteo/Rheumatoid Arthritis
__ TMJ/Jaw Pain
__ Cysts
__ Bursitis
__ Plantar Fasciitis
__ Tendinitis
__ Whiplash Syndrome
__ Carpal Tunnel Syndrome
__ Sciatica
__ Thoracic Outlet Syndrome

PLEASE COMPLETE BACKSIDE OF THIS FORM

__ Headache

RESPIRATORY
__ Pneumonia
__ Sinusitis
__ Asthma
__ Trouble Breathing

CIRCULATORY
__ Anemia
__ Hemophilia
__ Low or __ High Blood Pressure
__ Dizziness
__ Raynaud's Disease
__ Varicose Veins
__ Heart Condition
__ Blood Clots / Phlebitis
__ Diabetes Type 1 or 2

DIGESTIVE
__ Ulcers
__ Irritable Bowel Syndrome
__ Colitis
__ Gallstones
__ Hepatitis
__ Crohn's Disease
__ Constipation
__ Gas/Bloating
__ Indigestion

SKIN
__ Fungal Infection / Athletes Foot
__ Acne
__ Impetigo
__ Dermatitis/Eczema
__ Psoriasis
__ Open Wound/Sore – where?
_____
__ Rashes

NERVOUS SYSTEM
__ Numbness/Tingling/Twitching
__ ALS
__ Multiple Sclerosis
__ Parkinson's Disease
__ Bell's Palsy
__ Neuropathy/Neuralgia
__ Spinal Cord Injury
__ Stroke
__ Trigeminal Neuralgia
__ Seizure Disorders

OTHER
__ Insomnia
__ Anxiety/Panic Attacks
__ PMS
__ Depression
__ Grief Process
__ Cancer
__ Substance Abuse – Type:
_____
__ Chronic Fatigue
__ HIV / AIDS
__ Lupus
__ Kidney Disease
__ Bladder Infection
__ Postoperative Difficulties
__ Edema

Do you have any allergies? _____ Please describe: _____

FEMALES ONLY

Are you pregnant? Yes No

Do you have a regular menstrual cycle? Yes No

Please circle any of the following that apply: Irregular periods Missed Periods Painful Periods PMS

Heavy Flow Light Flow Endometriosis Infertility

Any other comments regarding menstruation or pregnancy? _____

Please indicate if you are currently experiencing any of the following conditions:

___ Cold/Flu ___ Fever ___ Contagious disease ___ Infection ___ Inflammation

Please rate your average daily energy level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Please rate your average daily stress level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Do you tend to feel excessively (circle if applicable) Hot Cold Sweaty ?

How many glasses of water do you drink daily? _____ How many hours of sleep do you average per night? _____

Circle those which you consume: Alcohol Caffeine Cigarettes Recreational Drugs

How often? _____

How often do you exercise? _____

Do you have a tendency to faint or become anxious around needles? Yes No

Do you bleed/bruise easily? Yes No

Please be advised that while the acupuncture needles are extremely small and normally do not elicit much, if any, bleeding that occasional bruising is a normal, although infrequent occurrence with acupuncture treatments. Please don't be alarmed if bruising does occur, however you are welcome to notify Jessica any time if you have concerns. The body's tendency to bleed may be affected by taking blood thinners, baby aspirin, other medications, or by individual deficiencies.

PLEASE READ AND SIGN

I acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information if necessary for insurance purposes. I clearly understand that acupuncture treatments are my personal financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made.

When I schedule an appointment for acupuncture, I understand that this time is reserved for me. In fairness to other patients, I agree to observe the 24-hour cancellation/rescheduling policy. If less than 24 hours' notice is given, I understand I may be charged $25. Signing this form is an agreement to this policy.

I also agree that I have been presented with a copy of the "Notice of Privacy Practices" for Tempe Acupuncture Center, detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: _____ **Date:** _____

If signed by someone other than the patient, please indicate your relationship to the patient and the patient's name.

Patient: _____

Relationship: _____