# Intake Form

Name _____ Date of Birth _____ Phone _____
email: _____ Address _____

1. Primary reasons for acupuncture treatment:_____
2. What surgeries/injuries/accidents have you had? Year?
   _____
3. Please list any current or past major illnesses or other hospitalizations: _____
   _____
4. Medications and supplements:_____
   _____
5. Emergency contact _____

Please check or **circle** any medical condition listed below that currently applies to you:

- ☐ Contagious skin condition
- ☐ Open sores or wounds
- ☐ Easy bruising
- ☐ Recent accident or injury or surgery
- ☐ Current fever / Swollen glands
- ☐ Inflammation/ swelling/ edema
- ☐ Allergies, rashes, or fungal infection
- ☐ Sinusitis

- ☐ Heart condition/ Stroke/ MI/ palpitations
- ☐ Atherosclerosis/ High Cholesterol (TG)
- ☐ High or low blood pressure
- ☐ Circulatory disorder/ Anemia
- ☐ Varicose veins/ Hemorrhoids
- ☐ Emphysema/ Bronchitis
- ☐ Asthma/ difficulty breathing
- ☐ Insomnia

- ☐ Depression/ Anger/ Irritability
- ☐ Anxiety/ Poor memory/concentration
- ☐ Joint disorder/ artificial joint/Dislocations
- ☐ Arthritis or gout
- ☐ Connective tissue disease
- ☐ Constipation/diarrhea/ IBS/ gas/ abdominal pain
- ☐ Drug, alcohol, caffeine, or tobacco use (circle and list frequency) _____

- ☐ Osteoporosis
- ☐ Tendonitis, bursitis
- ☐ Muscle spasm or cramps
- ☐ Sprains/ strains (location) _____
- ☐ Ringing in the ears
- ☐ Jaw pain

- ☐ Epilepsy
- ☐ Headaches/ migraines
- ☐ Infertility
- ☐ Menopause/ PMS
- ☐ Chronic fatigue/ Fibromyalgia
- ☐ Cancer
- ☐ Diabetes
- ☐ Erectile Dysfunction
- ☐ Decreased sensation/ neuropathy
- ☐ Thyroid dysfunction

- ☐ Hepatitis
- ☐ HIV
- ☐ Contagious condition

Other Significant: _____
_____

I hereby consent to consultation. I have listed all my known medical conditions and physical limitations and will inform the health care provider in writing of any change in my physical health or insurance plan between sessions. I understand that my health care provider must be aware of any and all existing physical conditions that I have in order to provide appropriate recommendations. I also understand that the health care provider will not diagnosis illness, disease, or any other medical, physical, or emotional disorder. I am responsible for consulting a qualified primary care provider for any ailment that may I have. **I agree to pay for missed services if I do not give 24 hour notice of cancellation.**

_____ _____ _____
Signature Name Date