Wellness
MEDICINE

Acupuncture Intake Form

Date: _____

Name: _____ DOB: _____

Address: _____

_____

Phone: (H) _____ (M) _____ (W) _____

Email: _____

Why are you seeking acupuncture? Please list your main complaint(s):

_____

_____

Does anything make the problem better or worse (e.g. application of heat; cold; movement; activity; weather conditions)?

_____

Overall how are your energy levels (poor, fair, good, excellent)? _____

Past Medical History

Childhood: (E.g. tonsils, recurrent ear/nose/throat infections; high fevers; robust or 'sickly')

_____

Traumas/Accidents: (E.g. bad falls; blows; fractures; bad tailbone injury; car accidents; psychological shocks; abuse of any form)

_____

Illness/Surgery: (E.g. glandular fever; hospitalizations; poor healing scars or injuries)

_____

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Medication/Drugs

Current prescribed medication(s): _____

Previous medications (significant amount/length of time taken e.g. repeated steroids, antibiotics, oral contraceptives, antidepressants, laxatives):

_____

Recreational drugs, past and/or present (e.g. marijuana, heroin, speed, ecstasy, acid)

_____

Cigarettes _____ Caffeine _____ Alcohol (mild, moderate, binge) _____

ACUPUNCTURE QUESTIONNAIRE

Please tick (√) any area or problem that you have now OR double tick (√√) if it has given you significant trouble in the past

- ☐ Feel 'flat' a lot
- ☐ Cold hands/feet
- ☐ Blush easily/facial flushing
- ☐ Jaw clenching/tooth grinding
- ☐ Easily irritated/tense
- ☐ Noise sensitivity
- ☐ Easily startled
- ☐ Aversion to wind/cold/humidity
- ☐ Difficulty concentrating
- ☐ Bruise easily
- ☐ Sigh a lot

- ☐ Bad shocks or traumas (psychological or physical)
- ☐ No appetite for breakfast
- ☐ Stomach often feels tight/clenched
- ☐ Ribs feel sensitive/guarded
- ☐ Claustrophobic

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- [ ] Anxiety/agitation

- [ ] Sleep
- [ ] Frequent colds or flu
- [ ] Chest tightness
- [ ] Hayfever
- [ ] Nose/sinus
- [ ] Ears
- [ ] Eyes
- [ ] Throat
- [ ] Mouth
- [ ] High or low blood pressure
- [ ] Dizziness/vertigo
- [ ] Bad headaches/migraine
- [ ] Varicose vein
- [ ] Skin
- [ ] Sweating

Females:

- [ ] Menstrual problems
- [ ] PMT
- [ ] Abnormal pap smears
- [ ] Number of pregnancies _____

Males:

- [ ] Prostate problem
- [ ] Low sex drive

- [ ] Digestion
- [ ] Appetite

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- [ ] Significant weight gain or loss
- [ ] Food allergies or sensitivities
- [ ] Food cravings
- [ ] Eating disorder
- [ ] Bloating
- [ ] Heartburn
- [ ] Energy drop in the afternoon

Would you say that your diet is at the present:

- [ ] Balanced, conscientious
- [ ] Not balanced, lots of junk
- [ ] Somewhere in between

Place an 'X' where you generally would be on the 'stool-line':

_____

(unformed/diarrhoea) (hard/dry)

- [ ] Urination
- [ ] Genital herpes
- [ ] Abnormal discharge
- [ ] STDs
- [ ] Bad tailbone injury
- [ ]
- [ ] Pain
- [ ] Often tight neck/shoulders
- [ ] Joint ache/pain/stiffness
- [ ] Low back stiff/ache
- [ ] Arthritis

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- [ ] Bone spurs, plantar fasciitis
- [ ] Painful/poor healing scar(s)

THANK YOU!

As a reminder, all information disclosed is strictly confidential