

## **Acupuncture Intake Form**

Date:	-		
Name:		DOB:	
Address:			
		(W)	
Email:			
Why are you seeking acup	uncture? Please list your main comp	laint(s):	
conditions)?		on of heat; cold; movement; activity; weather	
	y levels (poor, fair, good, excellent)?	, 	
Past Medical History			
Childhood: (E.g. tonsils, re	ecurrent ear/nose/throat infections; h	igh fevers; robust or 'sickly')	
Traumas/Accidents: (E.g. of any form)	bad falls; blows; fractures; bad tailb	one injury; car accidents; psychological shocks; abu	se

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



#### **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 ( $\sqrt{}$ ) any area or problem that you have <u>now</u> OR double tick ( $\sqrt{}$ ) if it has given you significant trouble in the <u>past</u>

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

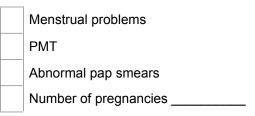
Claustrophobic



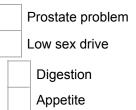
Anxiety/agitation

	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
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#### Females:



#### Males:



# Wellness Medicine

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 'stoolline':

(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



THANK YOU!

As a reminder, all information disclosed is strictly confidential