Acupuncture & Herbal Solutions

Acupuncture Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are confidential. If you have any questions, please ask.

Patient Information (Please Print)

Date:_____

Name:_____ Date of Birth:_____ Age:___

Address:_____

Phone: (H)_____(C)_____(W)_____ Email:_____
If there is a preference for which number to leave a message please note_____

Emergency Contact/Relationship:_____Phone:_____

Primary Physician:_____ Phone:_____

How did you hear of AHS?_____

Occupation:_____

Gender:_____ Height:_____ Weight:_____

Marital Status: Single Married Divorced Separated Partnership

Do you have any allergies?

__Food	__Environmental	__Essential Oils	__Medicine
List: _____	_____	_____	_____
_____	_____	_____	_____

Have you ever had acupuncture before? If so, was it for a particular issue:_____
_____

What is your primary reason(s) for treatment today?_____
_____

Have you consulted a medical doctor for this condition? If so, what was the diagnosis?
_____

Are you currently receiving any treatments for this condition? If yes, please describe them:
_____

Please list any medications (prescription & over the counter), vitamins, supplements, herbs or homeopathic remedies you are taking, including dosage:

_____ _____ _____ _____
_____ _____ _____ _____

Have you had or recently been exposed to COVID-19 or similar virus? If yes, list time frame since exposure: No Yes: _____

How much do you consume per day of the following:
Water_____Coffee_____Tea_____Soda_____ Alcohol_____ Cigarettes/other tobacco products:_____

Do you prefer: __warm drinks__cold drinks__room temperature drinks **Are you:** __always thirsty__rarely thirsty

What are your typical eating habits?
__Skip meals __Eat too fast __Eat when not hungry __Excess hunger __No desire to eat
__Cannot eat when stressed/worried __Vegetarian/Vegan __Craving specific foods/List_____

What are your typical sleeping habits? Hours slept at night:___
__Fall asleep quickly __Trouble falling asleep __Trouble staying asleep __Deep Sleeper
__Light Sleeper __Frequent dreaming __Disturbing dreams __Difficulty waking up
__Frequently wake up at the same time during the night __Other_____

How would you describe your energy levels?
__High __all day __varies __Low __all day __varies __Normal/Consistent __Chronic Fatigue

Do you have an aversion to any of the following?
__Cold __Wind __Dampness __Heat __Loud noises

What does your average body temperature feel like?
__Hot __Hot at night __Cold__Cold at night __Cold hands & feet __Night Sweats
__Sweat Easily __Sweating Difficult
__Hot other areas of the body/What areas? _____
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Cardiovascular: __Pacemaker/date_____ __Heart Disease __Blood Pressure High__Low__
__Chest Pain __Palpitations __Clots __Stroke __Varicose Veins __Edema __Poor Circulation
__High Cholesterol Other:_____

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Energy & Immunity: __Chronic Fatigue Syndrome __General Fatigue __Slow Wound Healing __Bruise easily
__Chronic Infections __Frequent Allergies
List type of infections?allergies & usual duration:_____

Neurological/Emotional: __Vertigo/Dizziness __Loss of balance __Numbness/Tingling __Paralysis
__Seizures/Epilepsy __Dyslexia __ADD/ADHD __Anxiety/Panic Attacks
__Mood Swings __Depression Mild/Clinical __Parkinson's __Poor Memory
__Anorexia/Bulimia __Alzheimer's __Dementia
Other:_____

Respiratory: __Asthma __Emphysema __Pnuemonia __COPD __Bronchitis
__Frequent Colds __Cough w/phlegm/blood __Chest Heavy/Tight __Tuberculosis
Other:_____

Genito-Urinary: __Kidney Disease __Kidney Stones __Incontinence
__Urination Frequent/Painful/Incomplete __Urine Dark/Light/Bloody
Other:_____

Gastrointestinal/Abdominal: __Heartburn/Acid Reflux __Gas __Nausea/Vomiting
__Ulcer __Bloating __Hermorrhoids __Gall Bladder Disease/Stones
__Hernia __Liver Disorder __Constipation/Diarrhea Bowel Movements Per Day___
__Stool Normal/Loose/Dry/Blood/Mucus __Pain before/during/after bowel movements
Other:_____

Head/Ear/Eye/Nose/Throat: __Glasses/Contacts __Cataracts __Glaucoma
__Impaired Vision __Dry/Tearing Eyes __Impaired Hearing __Ear Infections
__Ear Ringing High/Low Pitch __Ear Aches __Hearing Aids __Sinus Issues
__Nose Bleeds/Frequency__ __Dry Nose/Mouth __Teeth Grinding __TMJ
__Bleeding Gums __Frequent Sore Throat __Swollen Glands
Headaches Frequency_____ __Concussion #___ __Migraine Frequency_____
Other:_____

Skin/Hair: __Acne __Hives/Rashes __Dermatitis __Eczema __Psoriasis
__Shingles __Hair loss/thinning __Sensitive Skin
__Fungal Infection/Location/Frequency_____
Other:_____

Musculo-Skeletal: __Neck/Shoulder Pain __Muscle Spasms/Cramps __Osteoporosis
__Joint Pain __Arthritis Type_____ __Leg Pain
__Back Pain Low/Middle/Upper __Broken Bones Location_____
__Joint Replacements Type/Date_____Other:_____

Endocrine: __Thyroid Hyper/Hypo __Hypoglycemia __Diabetes __Other_____

Other: __Fibromyalgia __Lupus __Lyme Disease __Hepatitis A B C __HIV
__Herpes/Cold Sores __Hemophilia __Substance Abuse Type_____
Other:_____

Men: __Impotence __Prostrate Issues __Libido Low/High __Painful Intercourse
__ ED __Vasectomy/Date____ Other:_____

Women: Are you pregnant? No Possibly Yes/How far along?_____
# of pregnancies ___ # of miscarriages___ # of abortions___ #of deliveries__
Age @ first period___ Date of last menses_____ Age @ menopause____
Periods: #Days of flow___ __Regular __heavy/light __irregular
__Pain before/during/after __Color dark/bright/pale __Thin/thick/clots
Type of birth control:_____
__Endometriosis __Fibroids/Cysts __Genital Burning/Itching
__Genital Discharge __Hysterectomy/Date_____ __PMS Aches/Mood Swings
__Infertility __Libido Low/High __Painful Intercourse
__Breast lumps __Nipple Discharge __Mastectomy Date_____
Other:_____

Any comments or notes regarding any issue not covered on this form:_____
_____
_____