Acupuncture & Herbal Solutions

Acupuncture Intake Form

Please complete this questionnaire carefully and **thoroughly**. 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:_____City:_____State:_____Zip:_____

Phone: (C)_____(H)_____(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 Other_____

Do you have any allergies? Please specify.

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

Name:_____

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 of the following per day:

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 or worried __Vegetarian __Vegan
___Craving specific foods Please 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 long __varies __Low __all day long __varies __Normal/Consistent __Chronic Fatigue

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

What does your average body temperature feel like?
__Hot __Cold __Hot at night ___Cold at night __Cold hands & feet __Night Sweats
__Sweat Easily __Sweating Difficult
__Other Hot areas of the body/What areas? _____

Name:_____

Cardiovascular: __Pacemaker/date_____ __Heart Disease __Blood Pressure High Blood Preassure__Low
__Chest Pain __Palpitations __Clots __Stroke __Varicose Veins __Edema __Poor Circulation
__High Cholesterol Other:_____

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 Depression __Parkinson's __Poor Memory
__Anorexia __Bulimia __Alzheimer's __Dementia
Other:_____

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

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

Gastrointestinal/Abdominal: __Heartburn __Acid Reflux __Gas __Nausea __Vomiting
__Ulcer __Bloating __Hermorrhoids __Gall Bladder Disease __Gall Stones
__Hernia __Liver Disorder __Constipation __Diarrhea

How many Bowel Movements Per Day___ __Stool Normal __Stool Bloody __Stool Dry

__Pain before bowel movement __during bowel movement __after bowel movement
Other:_____

Head/Ear/Eye/Nose/Throat: __Glasses __Contacts __Cataracts __Glaucoma
__Impaired Vision __Dry Eyes __Tearing Eyes __Impaired Hearing __Ear Infections
__High Pitch Ear Ringing __Low Pitch Ear Ringing __Ear Aches __Hearing Aids __Sinus Issues
__Nose Bleeds/Frequency__ __Dry Nose __DryMouth __Teeth Grinding __TMJ
__Bleeding Gums __Frequent Sore Throat __Swollen Glands

Headache Frequency_____per week. __Concussions #___ __Migraine Frequency_____per week.
Other:_____

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

Name:_____

Musculo-Skeletal: __Neck Pain __Shoulder Pain __Muscle Spasms __Cramps __Osteoporosis
__Joint Pain __Arthritis Type_____
__Leg Pain
__Low Back Pain __Middle Back Pain __Upper Back Pain
__Broken Bones What Bones_____
__Joint Replacements Type/Date_____Other:_____

Endocrine: __Thyroid Hyper __ Thyroid Hypo __Hypoglycemia __Diabetes
__Other_____

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

Men: __Impotence __Prostrate Issues __Low Libido __High Libido __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 __Cramps

__Pain before period __Pain during Period __Pain after Period

__Dark color __bright color __pale color __Thin __Thick __Clots

Type of birth control:_____
__Endometriosis __Fibroids __Cysts __Genital Burning/Itching
__Genital Discharge __Hysterectomy/Date_____ __PMS Aches __Mood Swings
__Infertility __Libido Low __ Libido High __Painful Intercourse
__Breast lumps __Nipple Discharge __Mastectomy Date_____
Other:_____

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