Acupuncture Intake Form

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Holistichealthstl.com

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask.

Personal Information:

Name_____Birthdate_____/_____/_____Age____Gender_____
Address_____City_____State_____Zip_____
Phone numbers (please mark * next to best number):
Home_____Cell_____Work_____
E-mail address_____
Would you like to receive our e-newsletter with packages and discounts (sent out bi-annually)? □ Y □ N
Marital Status_____# of children _____their age(s)_____
Your Educational level _____Occupation _____
Would you like a superbill for reimbursement?_____ How did you hear about us? _____
Emergency Contact:
Name_____Ph_____Relationship_____

CHIEF COMPLAINT : Please describe what you are experiencing

_____
_____

Diagnosis by an
MD?_____
Lab results for the above_____
What other forms of treatment have you sought?_____
_____
_____

Medications, Herbs, Supplements (List those you are currently taking):_____
_____
_____

Family History (List any family physical or mental illnesses and age of death):

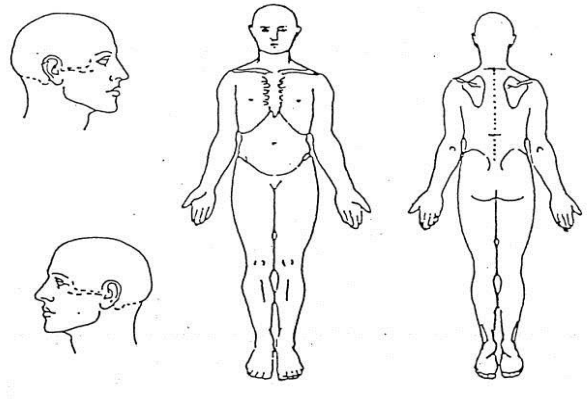
Mother_____
Father_____
Grandparents_____
Siblings_____
Children_____

Please list any traumatic experiences in the past year:

_____

MUSCULOSKELETAL

Please mark problem areas on diagram: Describe Pain and Location



□ Muscle Cramps – Where?
□ Muscle Pain / Rheumatism – Where?
□ Arthritis – Where?
□ Joint Swelling – Where?
□ Tendonitis – Where?
□ Bursitis – Where?

Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the PAST and do not have it now, check the box like this:
If you are having the symptom CURRENTLY, fill in the box like this:

Liver/Gallbladder

□ Depression / Stress
□ Headaches / Migraines
□ Red / Dry / Itchy Eyes
□ Visual Problems / Blurred Vision
□ Dizziness □ Gall Stones
□ Feeling of Lump in Throat
□ Clenching Teeth at Night
□ Muscle Cramping / Twitching
□ Neck/Shoulder Pain / Tightness
□ Seizures/Tremors
□ Poor Circulation
□ Soft/Brittle Nails
□ Bitter Taste in Mouth
□ PMS/Menstrual Problems
□ Do you crave: Sour
□ Tend to be Irritable / Angry

Heart/Small Intestine

□ Heart Palpitations □ Rapid or Irregular Heartbeat
□ Chest Pain
□ High/Low Blood Pressure (circle)
□ Insomnia / Sleep Problems
□ Vivid Dreams / Nightmares
□ Easily Startled
□ Dark
□ Red Complexion
□ Do you crave: Bitter
□ Anxiety / Nervous or Restless

Spleen/Stomach

□ Hard to get up in Morning
□ Muscles Often Feel Tired
□ Edema (□ Hands □ Feet)
□ Easily Bruising / Bleeding
□ Bad Breath
□ Sweetish Taste in Mouth
□ Lack of Taste
□ Excess or Low Appetite (circle which)
□ Excess or Lack of Thirst (circle which)
□ Nausea / Vomiting
□ Gas / Belching
□ Hemorrhoids
□ Organ Prolapse (i.e. uterus)
□ Chronic Loose Stools
□ Abdominal Pain
□ Brain Foggy
□ Mouth Ulcers
□ Tendency to Gain Weight
□ Do you crave: Sweet
□ Over-thinking / Worry

Lung/Large Intestine

□ Bloody Cough
□ Dry Cough
□ Chronic Cough
□ Cough with Sputum
□ Nasal Discharge- White, Yellow, or Green
□ Post Nasal Drip
□ Sinus Infection / Congestion
□ Itchy, Red, or Painful Throat
□ Dry Mouth / Nose / Throat
□ Skin Rashes / Hives
□ Snoring
□ Shortness of Breath
□ Allergies / Asthma
□ Low Immunity
□ Catch Colds Easily
□ Bronchitis
□ Black or Bloody Stools
□ Constipation
□ IBS
□ Diarrhea
□ Colitis / Spastic Colon
□ Do you crave: Pungent / Spicy
□ Grief / Sadness

Kidney/Urinary Bladder

□ Urinary Problems (i.e. night-time)
□ Frequent Bladder/BV Infection
□ Incontinence
□ Weakness / Pain in Low Back
□ Feel Cold or Hot Easily (circle which)
□ Cold Hands / Feet
□ Low or Excess Sex Drive (circle which)
□ Dark Circles under Eyes
□ Thyroid Problems
□ Poor Memory
□ Hair Loss / Grey Hair
□ Hearing Problems / Tinnitus
□ Cavities
□ Hot Flashes / Night Sweats
□ Impotence or Premature Ejaculation (circle which)
□ Do you crave: Salt
□ Fear