Chiropractic Today
Total Natural Health

Acupuncture Intake Form

The information provided on this form is confidential. It is important the information given is complete and accurate to assist you properly in your healing process.

Today's Date __ /__ /____

Name_____ Date of Birth __ / __ / ____ Age:____ Sex:_____

Address_____

City/State/Zip_____ Email:_____

Telephone: (home)_____ (cell)_____

Emergency Contact Person/Relationship_____

Phone Number_____

Primary Care Physician_____

How did you hear about us?_____

What are the concerns for which you are seeking care? (Symptoms, diagnosis, and date of onset)

1. _____
2. _____
3. _____

Treatment received for concerns listed: _____

What makes your complaint better?

_____

What makes your complaint worse?

_____

Significant trauma, Hospitalizations, Surgery, X-rays, Special studies

_____

_____

_____

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List any Allergies

Are you hypersensitive or allergic to any foods, drugs, chemical or environmental substances?

_____

Medications and Supplements

Name	Reason	Date started	Dosage	Helpful Yes or No

Exercise, Energy, and Dietary:

How much exercise per week _____ Length of workout_____ Activities_____

How is your energy level?_____ When is it the lowest?_____ Highest?_____

Dietary Overview

Meals per day:_____ Number of Snacks_____ Caffeinated Drinks_____ Alcohol/week_____

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Food cravings or avoidances?_____

Water intake per day?_____ Prefer warm or cold drinks?_____

Excessively thirsty? Yes/No Special Diet:_____

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Personal History: check all that apply

❑ Heart Disease	❑ Kidney Disease	❑ Cancer	❑ Chronic Pain	❑ Alzheimer's
❑ High/Low Blood Pressure	❑ Stroke	❑ Seizures	❑ Fatigue	❑ Alcohol or Drug Addiction
❑ Hepatitis	❑ Anemia	❑ Ulcers	❑ Infertility	❑ Eating Disorder
❑ HIV	❑ Blood Clotting Disorder	❑ Anemia	❑ Autoimmune Conditions	❑ Organ Removal
❑ AIDs	❑ Diabetes	❑ Thyroid Conditions	❑ Asthma	❑ Ulcer/ Hemorrhoids

Other serious health conditions:_____

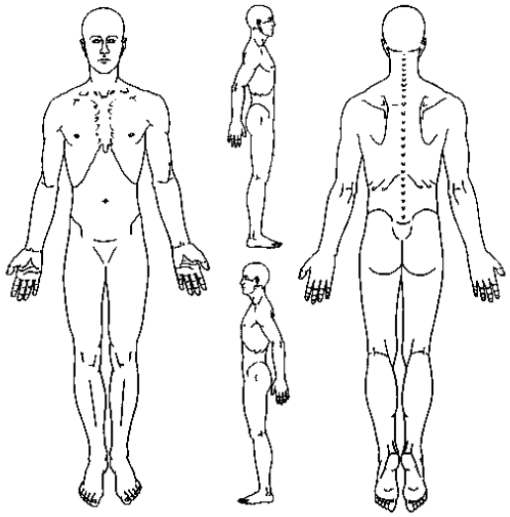
Tobacco use (Smoking, chew, snuff):_____ How long:_____ Amount:_____

F**amily History:** Please check any condition that applies to your immediate family: (M) Mother, (F) Father, (S) Sister, (B) Brother, (GM) Grandmother, (GF) Grandfather

❑ Heart Disease	❑ High Blood Pressure	❑ Stroke	❑ Diabetes	❑ Cancer

Other serious health conditions: _____

Mark all areas of pain on the diagram below



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Additional Patient History

General		
❑ Poor Appetite	❑ Poor Sleep	❑ Poor Balance
❑ Chills	❑ Night Sweats	❑ Peculiar Taste/Smells
❑ Cravings	❑ Localized Weakness	❑ Fevers
❑ Bleed/Bruise Easy	❑ Weight Loss/Gain	❑ Tremors
❑ Muscle Weakness/Fatigue	❑ Strong Thirst (hot/cold drinks)	❑ Change in Appetite
	❑ Fatigue	❑ Dental/Gum Problems
	❑ Sweat Easily	

Skin and Hair		
❑ Rashes	❑ Dandruff	❑ Itching
❑ Eczema	❑ Acne	❑ Moles
❑ Skin Discolorations	❑ Hives/Allergic Dermatitis	❑ Face Flushing
❑ Ulcerations	❑ Loss of Hair	❑ Change in Skin/Hair Texture

Head, Ears, Nose, Throat		
❑ Dizziness	❑ Difficulty Swallowing	❑ Astigmatism
❑ Eye Strain	❑ Eye Pain	❑ Night Blindness
❑ Color Blindness	❑ Cataracts	❑ Spots in Front of Eyes
❑ Ringing in the ear	❑ Poor Hearing	❑ Teeth Grinding
❑ Nose Bleed	❑ Recurrent Sore Throats/Cold	❑ Jaw Clicks/Locks
❑ Headaches (where & when)	❑ Dental Problems	❑ Earaches
	❑ Migraines	❑ Sinus Problems
	❑ Poor Vision	❑ Facial Pains

Cardiovascular		
❑ Chest Pain	❑ Irregular Heart Beat	❑ Fainting
❑ Cold Hands/Feet	❑ Swelling of Hands/Feet	❑ Phlebitis
❑ Shortness of Breath	❑ Varicose/Spider Veins	
	❑ Palpitations at Rest	
	❑ Pressure in Chest	

Respiratory		
❑ Cough	❑ Difficult to Inhale/Exhale	❑ Asthma
❑ Pneumonia	❑ Coughing Blood	❑ Tight Sensation in Chest
	❑ Pain with Deep Inhalation	❑ Bronchitis
	❑ Production of phlegm	❑ Wheezing

Gastrointestinal		
❑ Nausea	❑ Vomiting	❑ Black Stools
❑ Gas	❑ Belching	❑ Blood in Stools
❑ Indigestion	❑ Bad Breath	❑ Abdominal Cramps/Pain
❑ Bloating	❑ Chronic Use of Laxatives	❑ Loose Stools
	❑ Acid Reflux	❑ Hemorrhoids
	❑ Diarrhea	❑ Constipation

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Urogenital ❑ Pain on Urination ❑ Unable to hold Urine ❑ Impotence ❑ Premature Ejaculation	❑ Frequent Urination ❑ Kidney Stones ❑ Sores on Genitals ❑ Decreased Libido ❑ Blood in Urine ❑ Scanty Flow	❑ Urinary Tract Infection ❑ Prostatitis ❑ Urgent Urination ❑ Copious Flow ❑ Burning Urination ❑ Dribbling after Urination
Female Only ❑ Irregular Cycle ❑ Bleeding Between Cycles ❑ Pain during Intercourse ❑ Clotting ❑ Heavy or Excessive Flow ❑ PMS	❑ Painful Menses ❑ Vaginal Discharge ❑ Vaginal Itching/Burning ❑ Vaginal Odor ❑ Menopausal Symptoms ❑ Vaginal Dryness ❑ STDs ❑ Breast Pain/Tenderness	❑ Nipple Discharge ❑ Breast Lumps ❑ Ovarian Cysts ❑ Endometriosis ❑ Uterine Fibroids ❑ PCOS ❑ Pelvic Inflammatory Disease
Males Only ❑ Hernias ❑ Testicular Masses ❑ Testicular Pain	❑ Varicoceles ❑ STD ❑ Premature Ejaculation ❑ Impotence ❑ Prostate Disease	❑ Discharge or Sores ❑ Sexual Dysfunction
Musculoskeletal ❑ Neck Pain ❑ Knee Pain ❑ Hip Pain ❑ Bursitis	❑ Back Pain (lower) ❑ Back Pain (Middle) ❑ Back Pain (upper) ❑ Sprains/Strains ❑ Muscle Pains ❑ Hand/Wrist Pain	❑ Sciatica ❑ Muscle Weakness ❑ Carpal Tunnel ❑ Shoulder Pain ❑ Foot/Ankle Pain ❑ Tendonitis
Neuropsychological ❑ Seizures ❑ Loss of Balance ❑ Vertigo/Dizziness ❑ Areas of Numbness	❑ Lack of Coordination ❑ Poor Memory ❑ Concussion ❑ Depression ❑ Seasonal Depression	❑ Easily Stressed ❑ Anxiety/Panic Attacks ❑ Irritable

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