Creative Health

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Acupuncture Intake Form

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information:

Name:____ Age:_____________ Today's Date:_______________
Address:_________________________________ City:___________________ State:__________ Zip:__________
Home Phone:_________________ Work Phone: _________________ Email:______________________________
DOB:________________ If under 18, person responsible for your account: _____________________________
Emergency Contact:____________________________________ Contact Phone:_________________________
How did you hear about us? ____
Have you had acupuncture therapy before? ☐YES ☐NO With Whom? _____________________________

Please indicate if any of the following pertain to you (marking "yes" does not make you ineligible for treatment; however, it may restrict some of our treatment modalities):

☐Hepatitis ☐HIV ☐High Blood Pressure ☐Seizures ☐Pacemaker ☐Blood-thinning Meds ☐Pregnancy

Please indicate the use and frequency of the following:

Coffee____________________ Soda____________________ Water____________________
Alcohol___________________ Rec. Drugs_______________ Tobacco___________________

Please list any prescriptions, herbs, over the counter medications you are presently taking:

Medication	Reason
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

Health History

What are the health concern(s) for which you are seeking treatment? __________________________________
____
____
How long have you had this condition? ____
What other forms of treatment have you sought? ____
____
What aggravates your condition? ____
____
Please list any surgeries or major health incidents (accidents, etc.) in your life: ___________________________
____

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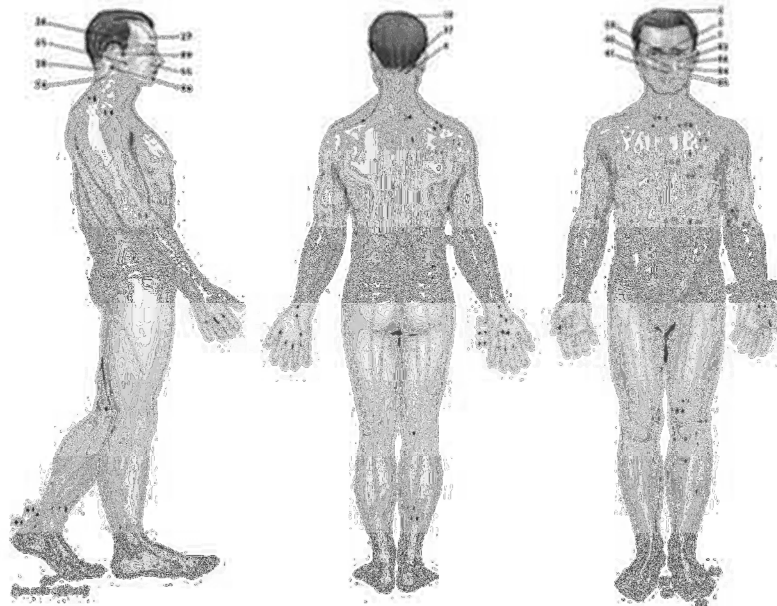
PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain?

☐Dull/Achy ☐Sharp/Stabbing ☐Burning ☐Tingling ☐Numbness ☐Electrical

Symptom Survey

Please check the symptoms or conditions you experience frequently.

Sp/St

- ☐ Excessive appertite
- ☐ Loose stool/diarrhea
- ☐ Digestive problems, indigestion
- ☐ Vomiting
- ☐ Belching/burping
- ☐ Heartburn/reflux
- ☐ Stomach bloating
- ☐ Obsession in work, relationships, etc.
- ☐ Lack of appetite

Ht/P

- ☐ Insomnia
- ☐ Palpitations
- ☐ Cold hands/feet
- ☐ Nightmares
- ☐ Mentally restless
- ☐ Laughing for no reason
- ☐ Chest pains
- ☐ Poor memory
- ☐ sadness

Lu/Li

- ☐ Cough
- ☐ Shortness of breath
- ☐ Decreased sense of smell
- ☐ Nasal problems
- ☐ Skin problems
- ☐ Claustrophobia
- ☐ Colitis/diverticulitis
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Recent use of antibiotics

Ki/UB

- ☐ Low back pain
- ☐ Knee problems
- ☐ Hearing impairment
- ☐ Ear ringing
- ☐ Kidney stones
- ☐ Decreased sex drive
- ☐ Hair loss
- ☐ Urinary problems
- ☐ Easily bruised
- ☐ Dental problems

Liv/GB

- ☐ Eye problems
- ☐ Jaundice
- ☐ Difficulty digesting oily foods
- ☐ Gall stones
- ☐ Light colored stool
- ☐ Soft/brittle nails
- ☐ Easily angered
- ☐ Difficulty making decisions
- ☐ High cholesterol
- ☐ Bitter taste

☐Fatigue ☐Edema ☐Asthma ☐Allergies ☐Dizziness ☐Get sick easily ☐Headaches ☐I usually feel warm ☐I usually feel chilled

For Women Only:

Age of first period________ Date of last period_________ Number of children (live births)_________

Number of days between periods (your cycle)__________ Number of days of flow__________

Color of flow: ☐pale/light red ☐red ☐bright red ☐dark red ☐dark red/brown ☐clots

Amount of flow: ☐spotting ☐light ☐even throughout ☐heavy

# of pads you use per day? 1st day____ 2nd day____ 3rd day____ 4th day_____ + days____

Pain and cramping: ☐NO ☐YES: __Before flow __During flow __After flow __Mild __Moderate__Severe

Other symptoms related to menses: ☐Discharge ☐PMS ☐Headache ☐Nausea ☐Constipation ☐Diarhhea ☐Swollen breasts ☐Mood swings ☐Increased appetite ☐Decreased appetite ☐Insomnia

Have you ever been diagnosed with: ☐Fibroids Fibrocystic ☐Breasts Endometriosis ☐Ovarian cysts ☐PID ☐Polycystic ovary syndrome ☐STD______________________