common SENSE HEALING
Acupuncture & Holistic Health Care

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ACUPUNCTURE INTAKE FORM

Name: _____ Date: _____

Name you would like to be called: _____

Street: _____

City: _____State:_____ Zip:_____

Email Address: _____

Home Phone: _____Cell Phone: _____

Gender □ Female □ Male Date of Birth: _____ Age:_____

Height: _____feet_____inches Weight: _____lbs.

How did you hear about us? _____

Were you referred by someone? Who can we thank? _____

Marital Status: □ Married □ Never Married □ Widowed □ Divorced or Separated

Occupation: _____Retired: ___ Disabled: ____Unemployed: ____

Emergency Contact: _____ Relation to you: _____

Emergency Contact's Phone Number: _____

Name DOB

Family Physician/Group/PA/NP: _____

Physician's Phone Number: _____ Physician's City: _____

Chiropractor: _____ Massage Therapist: _____

Other Specialist's Name(s): _____

_____

_____

Have you ever had Acupuncture before? □ Yes □ No

Main problem you would like to focus on: _____

_____

Date problem began: _____

Have you been given a diagnosis for this problem? □ Yes □ No

If so, what was the diagnosis? _____

What other kinds of treatment have you tried? □ Acupuncture □ Massage
□ Physical Therapy □ Chiropractor □ Herbs/Supplements/Essential Oils
□ Homeopathy □ Other Methods: _____

Are you currently undergoing Chemotherapy or Radiation Treatment: □Yes □ No

If yes: Oncologist / Group treating you:

_____

Allergies – please list any known allergies (ex. food, hay fever, pollen, drugs, medication, etc.):

_____

_____

Stress Level (1=No Stress, 10=High Stress) _____ Cause of Stress:_____

Significant Family History: _____

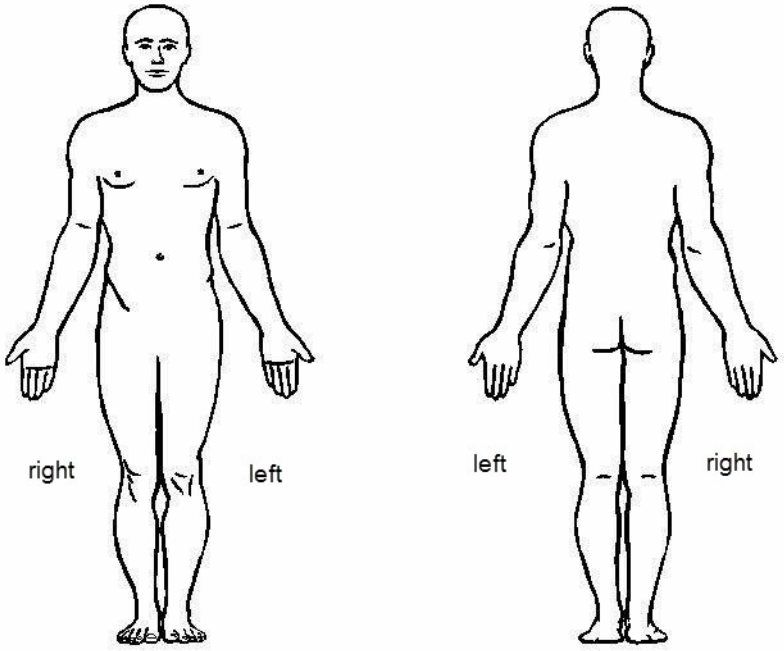
_____

Name DOB

Pregnancy History: □ Living _____ □ Ectopic _____ Miscarriages_____ □ IVF/IUI
# of Rounds of IUI/IVF:_____

Are you currently pregnant? □ Yes □ No If yes, what is your due date? _____

Location of Pain:
(on the diagram below please circle ○ areas of pain or mark X for numbness/tingling)



Circle quality of pain:

Aching	Heavy
Throbbing	
Shooting	Stabbing
harp	
Hot	Burning
Cramping	
Numbness	Tingling
Distending	

How long have you had this pain:
□ 3 months or less
□ 3 – 6 months
□ 6 months-1 year
□ 1year-2years
□ more than 2 years

How often does this pain occur?
□ Continuously
□ 1 or 2 Times a Day
□ Several Times a Day
□ Several Days a Week
□ Less than 4 times a Month

What caused the pain? _____

Name DOB

For the following sections, please check off all symptoms that you are experiencing now. Put a letter P for any symptoms you had in the past 5 years:

	nausea		gas		diarrhea
	vomiting		abdominal bloating		constipation
	belching		abdominal pain		blood in stools/black stools
	GERD/heartburn		irritable bowel syndrome		pus in stools
	bad breath		indigestion		hemorrhoids
	bleeding gums		low energy / fatigue		anal fissures
	ulcers		crave sweets		rectal pain
	excessive appetite		decreased ability to taste or smell		varicose veins

	decreased appetite		sweet taste in mouth		prolapsed organ
	acne		worry/ over thinking/ anxiety		difficulty swallowing
	nose bleeds		edema		loose bowel movement

	frequent colds		asthma		dry skin
	sinus infection		bronchitis		itching
	cough		pneumonia		weak voice
	cough with blood		COPD		rashes
	production of phlegm		short of breathe		hives
	hay fever or allergies		psoriasis		eczema
	laryngitis		front shoulder pain		often feel sadness or grief
	frequent urination		breast lumps		impotence
	urgency to urinate		fibrocystic breast		premature ejaculation

	pain on urination		pelvic inflammatory disease		testicular lumps
	urine / bowel incontinence		abnormal PAP smear		prostatitis
	weak urine stream		irregular periods		low libido
	blood in urine		premenstrual syndrome		genital itching / pain
	frequent urinary tract infections		painful menstrual periods		genital lesions /
	kidney stones		abnormal bleeding		decreased libido
	sore / weak knees		menopause symptoms		decreased hearing
	low back pain		frequent vaginal infections		ear ringing – low pitch
	often feel afraid		infertility		ear ringing – high pitch
	endometriosis		vaginal discharge		ear infections
	fibroids/ovarian cysts				crave salty foods
	dry eyes		insomnia		migraine
	red eyes		excessive / vivid dreams		dizziness
	eye inflammation		grinding teeth		fainting
	blurred vision		depression		seizures
	poor night vision		anxiety / stress		localized weakness
	cataracts		Irritability		numbness or tingling of limbs
	glaucoma		treated for emotional / psychological problems		tremors
	glasses / contact lenses		indecisiveness		poor coordination
	visual changes		often feel angry		paralysis
	rib pain		Bell’s Palsy		aversion to wind
	abdominal/chest constriction		crave sour foods		tendonitis
	sighing		hiccups		gallstones

	high blood pressure		chest pain or pressure		blood clots/ clotting disorder
	low blood pressure		jaw, neck, shoulder or arm pain		phlebitis
	palpitations		nausea		poor memory
	irregular heartbeat		swollen hands or feet		crave bitter foods
	floaters (black spots in visual field)		anemia		irritability
	fevers		chills		headache
	frequent or strong thirst		cold hands / feet		neck stiffness
	tend to feel warmer than others		tend to feel colder than others		concussion
	night sweats		cold sweats		enlarged lymph glands

	thirsty		prefer cold food and drink		prefer warm food and drink

	arthritis		immune compromised		auto immune disease

Major Hospitalizations or Surgeries: continue on back if necessary.

Year Operation or Illness

_____

_____

_____

Prescription Drugs: list all current prescribed medications: continue on back if necessary:

_____

_____

_____

Herbs & Supplements: list all current herbs & supplements: continue on back if necessary:
_____

_____

_____

Other past or current infections: □ Covid-19 □ Flu □ Pneumonia □ Lyme Disease
□ E. coli □ Mono/Epstein Barr □Shingles □ Chicken Pox □ Measles □ Mumps
□HIV □ TB □ Hepatitis □ MRSA □ C-Diff □ Strep □ RSV □ Other:_____

Vaccines: □ Covid-19 □ Flu □ Pneumonia □ Hepatitis □ DPT
□Shingles □ Chicken Pox □ Measles □ Mumps

What time do you typically go to sleep? _____am / pm

What time do you typically wake up? _____ am/pm

Do you fall asleep easily? □ Yes □ No

Is it difficult to stay asleep? □ Yes □ No

Do you wake feeling rested? □Yes □No

Do you have nightmares or vivid dreams? □ Yes □ No

Do you have enough energy for your lifestyle? □ Yes □ No

Do you have a regular exercise program? □ No □ Yes If yes, please describe:

_____

Do you follow any special diet (e.g., vegetarian vegan, medical related, etc.)?
□ No □ Yes If yes, what type? _____

Do you wish to cut down on unhealthy foods? If yes, please describe: _____

_____

Do you smoke? (Includes Vape & Marijuana) □ No □ Yes If yes, please describe: _____

_____

Name DOB

Do you use drugs for non-medical purposes? □ No □ Yes If yes, please describe: _____
_____

How many cups of caffeinated coffee, tea, or cola do you drink per week? _____
How many 8 oz. glasses of water do you drink per day? _____
How many alcoholic beverages do you drink per week? _____
Do you exercise? □ Yes □ No □ Gym □ Walking □ Running □ Cycling □Yoga

Other: _____ # of times per week:_____

Has your water been tested? □ Yes □ No

Have you ever had an air quality or mold issue in your home? □ Yes □ No

Has your home been tested for radon? □ Yes □ No

Thank you for your time completing your health assessment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Acupuncturist Date