



# Advanced Acupuncture Center Intake Form

Name Last- \_\_\_\_\_ First \_\_\_\_\_ SSN # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender F \_\_\_\_\_ M \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Marital Status: \_\_\_\_\_ Education (Highest grade or degree achieved) \_\_\_\_\_

Option: Height \_\_\_\_\_ Weight \_\_\_\_\_ HIV \_\_\_\_\_ HbsAg \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Have you been treated by Acupuncture or Oriental medicine before? \_\_\_\_\_

## Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's signature (Parent or Guardian if under 18) \_\_\_\_\_ Date \_\_\_\_\_

In an Emergency Notify Name \_\_\_\_\_ Relationship to client \_\_\_\_\_

Phone (Day) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Evening) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

1. Main problem you would like us to help you with: \_\_\_\_\_
2. How long ago did this problem begin? \_\_\_\_\_
3. Have you been given a diagnosis for this problem? If so, what? \_\_\_\_\_
4. What kinds of treatment have you tried? \_\_\_\_\_
5. Are you currently receiving treatment for your problem? \_\_\_\_\_ If so, please describe: \_\_\_\_\_
6. Does anything improve your problem? \_\_\_\_\_

## PAST MEDICAL HISTORY

Illnesses: \_\_\_\_\_

Surgeries \_\_\_\_\_

Significant Trauma (Auto accidents, falls, etc.) \_\_\_\_\_

Do you have, or have you ever had, any **Infectious Diseases**? Yes  No

If so, please describe \_\_\_\_\_

**Medicines** (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

**Allergies:**

**FAMILY MEDICAL HISTORY (GENERAL HEALTH)**

Mother's Side \_\_\_\_\_  
Father's Side \_\_\_\_\_  
Siblings \_\_\_\_\_  
If any of the above is deceased, what was the cause? \_\_\_\_\_

**PERSONAL HISTORY**

Birth History (Prolonged labor, forceps, delivery, etc.) \_\_\_\_\_  
Childhood health \_\_\_\_\_  
Location of upbringing (Geographically prone to certain diseases, habits, etc.) \_\_\_\_\_  
Current Emotional Health \_\_\_\_\_  
Current Quality of Life \_\_\_\_\_  
Current Relationship/Quality \_\_\_\_\_  
Current Predominant Emotion \_\_\_\_\_  
Occupation \_\_\_\_\_ Stress Level \_\_\_\_\_  
Have you had any unusual stresses recently? \_\_\_\_\_  
Favorite time of year (body type) \_\_\_\_\_ Worst \_\_\_\_\_  
Hobbies & Recreational Habits \_\_\_\_\_  
Do you have a regular exercise program? Yes  No  If so, please describe: \_\_\_\_\_  
Have you traveled abroad in the past year? Yes  No  Where? \_\_\_\_\_  
If applicable, please describe smoking or alcohol intake : \_\_\_\_\_

**NEUROPSYCHOLOGICAL**

<input type="checkbox"/> Seizures	<input type="checkbox"/> Areas of Numbness	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Concussion	<input type="checkbox"/> Lack of Coordination	<input type="checkbox"/> Poor Memory
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Easily Angered
<input type="checkbox"/> Headaches	<input type="checkbox"/> Fainting	<input type="checkbox"/> Depression
<input type="checkbox"/> Migraines	<input type="checkbox"/> Disorientation	<input type="checkbox"/> Mania
<input type="checkbox"/> Easily Susceptible to Stress		

Have you ever been treated for emotional problems? \_\_\_\_\_  
Have you ever considered or attempted suicide? \_\_\_\_\_  
Any other neurological or psychological problems? \_\_\_\_\_  
Any nervous habits? \_\_\_\_\_

**PREGNANCY & GYNECOLOGY**

___ Age at First Menses	___ Number of Pregnancies	<input type="checkbox"/> Birth Control?
___ Period between Menses	___ Number of Births	What type? _____
___ Duration of Menses	___ Miscarriages	How long? _____
<input type="checkbox"/> Unusual Character	___ Abortions	<input type="checkbox"/> Fertility Problems
<input type="checkbox"/> Heavy or <input type="checkbox"/> Light	<input type="checkbox"/> Difficult Births	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Vaginal Sores
<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Clots	

First Date of Last Menstrual Cycle \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Last Pap Smear \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Do you experience changes in Body and/or Psyche prior to menstruation ? \_\_\_\_\_

**PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)**

**GENERAL**

- |                                  |                                       |  |
|----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Fevers  | <input type="checkbox"/> Tremors      | <input type="checkbox"/> Change in Appetite        |
| <input type="checkbox"/> Chills  | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sudden energy drops?      |
- What time of Day? \_\_\_\_\_
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Poor Sleep/ Insomnia  | <input type="checkbox"/> Day Sweating  | <input type="checkbox"/> Strong thirst for Hot or Cold drinks? |
| <input type="checkbox"/> Dream Disturbed Sleep | <input type="checkbox"/> Poor Balance  | <input type="checkbox"/> Headaches                             |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Weight Loss   | <input type="checkbox"/> Localized Weakness                    |
| <input type="checkbox"/> Mania                 | <input type="checkbox"/> Weight Gain   | <input type="checkbox"/> Bleeding or Bruising                  |
| <input type="checkbox"/> Emotional Changes     | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Joint Pain                            |

**CARDIOVASCULAR**

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Swelling of Hands       | <input type="checkbox"/> Blood Clots  |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Difficulty in Breathing | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Cold Sweats      | <input type="checkbox"/> Cold Hands/Feet         |                                       |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Phlebitis               |                                       |

**RESPIRATORY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cough                                      | <input type="checkbox"/> Pain w/ Deep Breaths | <input type="checkbox"/> Difficulty in Breathing |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Shortness of Breath     |
| <input type="checkbox"/> Easily Winded w/ Exertion when laying down |   | <input type="checkbox"/> Coughing Blood          |
| <input type="checkbox"/> Production of phlegm                       | What Color? _____                             |  |

**GASTROINTESTINAL**

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Nausea      | <input type="checkbox"/> Abdominal Pain/ Cramps | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Vomiting    | <input type="checkbox"/> Parasites              | <input type="checkbox"/> Constipation        |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Belching               | <input type="checkbox"/> Diarrhea            |
| <input type="checkbox"/> Ulcers      | <input type="checkbox"/> Bad Breath             | <input type="checkbox"/> Blood in Stools     |
| <input type="checkbox"/> Hernia      | <input type="checkbox"/> Hemorrhoids            |  |

**GENITO-URINARY**

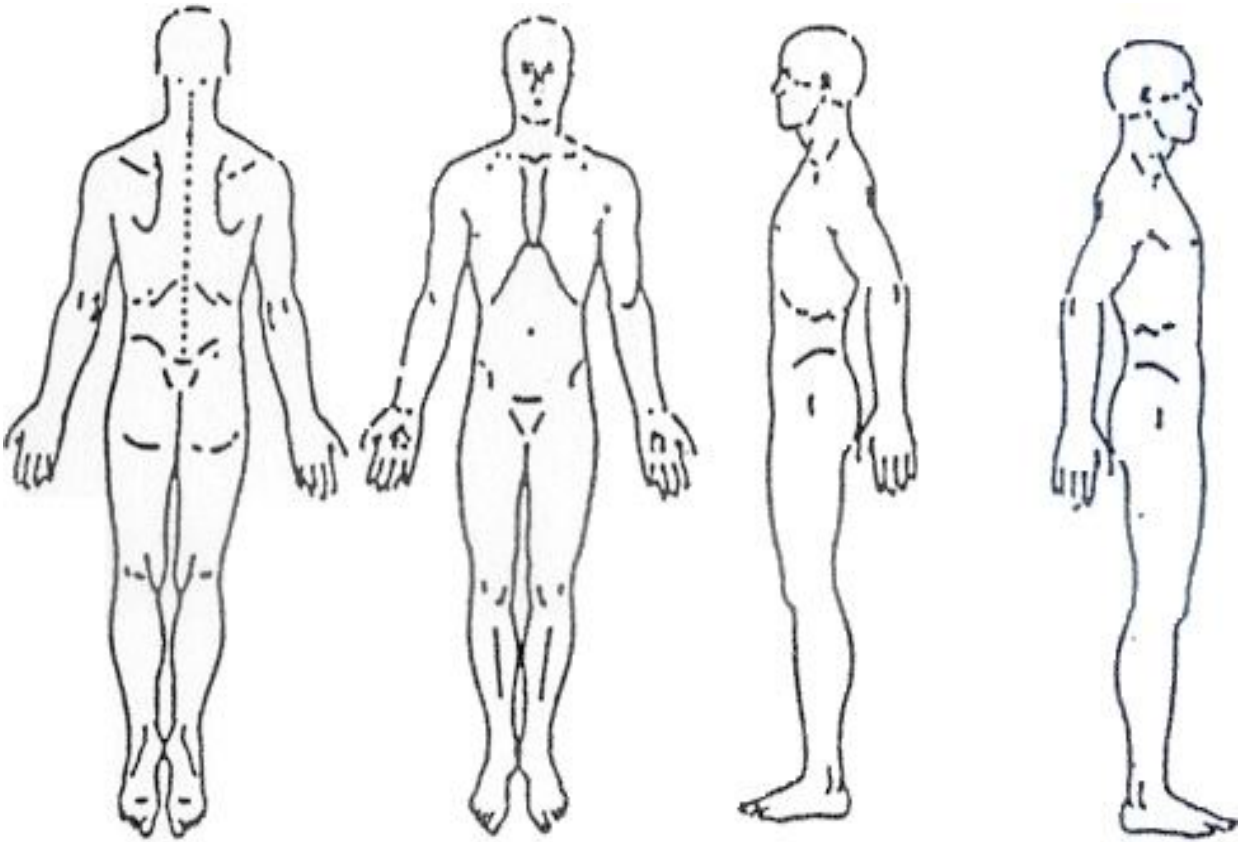
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pain on Urination    | <input type="checkbox"/> Decrease in Urine      | <input type="checkbox"/> Kidney sores         |
| <input type="checkbox"/> Urgent Urination     | <input type="checkbox"/> Blood in Urine         | <input type="checkbox"/> Waking up to Urinate |
| <input type="checkbox"/> Frequent Urination   | <input type="checkbox"/> Impotency/ Infertility | How often? _____                              |
| <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Genital Sores          |   |

**MUSCULOSKELETAL**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Recent Sprains |
| <input type="checkbox"/> Muscle Cramps     | <input type="checkbox"/> Spasms            |   |
| <input type="checkbox"/> Injuries or Falls | <input type="checkbox"/> Muscular Atrophy  |   |
| <input type="checkbox"/> General Aches     | <input type="checkbox"/> Joint Instability |   |

Please circle on the diagram any areas of any type of pain or injury.

Please try to describe the type and quality of the pain \_\_\_\_\_



Are there any other internal organ or systemic dysfunctions that we should be aware of? \_\_\_\_\_

Are there any other problems you would like to discuss? \_\_\_\_\_