###### 

###### ACUPUNCTURE WORKS INTAKE FORM

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone/ Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESENT HEALTH CONCERNS:** Please list your most important health concerns in order of their significance.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approx. Date of Onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approx. Date of Onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approx. Date of Onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list **allergies** that you have to any of the following:

Drugs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Foods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (i.e. pollen, paint, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### HEALTH HISTORY

##### Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Habits:**

☐Tobacco packs/day\_\_\_\_\_\_\_\_\_\_

☐Alcohol drinks/wk\_\_\_\_\_\_\_\_\_\_\_

☐Coffee/tea/cola cups/day\_\_\_\_\_\_\_\_\_\_\_

☐Recreational drugs times/wk\_\_\_\_\_\_\_\_\_\_\_

☐High Stress Level Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you follow any diet regimens/restrictions?

☐Yes ☐No

If Yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Activity:**

☐Sitting % of time\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Standing % of time\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Light labor % of time\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Heavy labor % of time\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise:**

Do you exercise regularly? ☐Yes ☐No

If Yes, describe & tell how often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### FAMILY INFORMATION

Do you have children? ☐Yes ☐No If Yes, how many?\_\_\_\_\_\_\_\_\_\_Ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you, or could you be currently pregnant? ☐Yes ☐No Due date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you have had (in the **last three months**)

GENERAL

* Poor appetite
* Heavy appetite
* Changes in appetite
* Weight loss/gain
* Cravings
* Peculiar tastes
* Strong thirst
* Fevers/Chills
* Sweat easily
* Localized weakness
* Bleed / bruise easily
* Sudden energy drop (time?)
* Fatigue
* Tremors
* Poor sleeping
* Heavy sleeping
* Dream disturbed sleep
* Night sweats
* Dizziness

SKIN AND HAIR

* Rashes/Hives
* Itching
* Dry skin
* Dandruff
* Ulcerations
* Eczema/Psoriasis
* Loss of hair
* Pimples/Acne
* Fungal infections
* Recent moles
* Change in hair or skin texture

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE, AND THROAT

* Concussions
* Glasses/Contacts
* Eye strain/pain
* Red eyes
* Itchy eyes
* Dry eyes
* Excessive tearing
* Poor/blurry vision
* Night blindness
* Cataracts/Glaucoma
* Spots in front of eyes
* Earaches/Infections
* Ringing in ears
* Poor hearing
* Sinus problems
* Post nasal drip
* Excessive phlegm – color\_\_\_\_\_\_\_\_\_\_\_\_
* Nose bleeds
* Recurrent sore throats
* Swollen glands
* Sores on lips/tongue
* Dry mouth
* Excessive saliva
* Teeth problems
* Gum problems
* TMJ disorder
* Grinding teeth
* **Headaches** (location, triggers, severity)?

Other head & neck concerns:

CARDIOVASCULAR

* High blood pressure
* Low blood pressure
* Chest pain
* Irregular heartbeat
* Palpitations
* Fainting
* Cold hands/feet
* Swelling of hands
* Swelling of feet
* Blood clots
* Phlebitis

Other heart or blood vessel concerns:

RESPIRATORY

* Cough
* Coughing blood
* Wheezing
* Asthma
* Bronchitis
* Pneumonia
* Pain with deep breath
* Shortness of breath
* Tight chest
* Production of phlegm - color?\_\_\_\_\_\_\_\_ Is it ☐thick or ☐thin

Other lung related concerns:

GASTROINTESTINAL

* Nausea
* Vomiting
* Diarrhea
* Constipation
* Gas/Bloating
* Hiccups
* Belching
* Bad breath
* Blood in stools
* Black stools
* Mucus in stools
* Acid Regurgitation
* Abdominal pain
* Itchy anus
* Burning anus
* Hemorrhoids/fissures

History of chronic laxative use?

Other concerns with your general digestion:

GENITO-URINARY

* Pain on urination
* Frequent urination
* Blood in urine
* Urgency to urinate
* Unable to hold urine
* Decrease in flow
* Bedwetting
* Kidney stones
* Impotency
* Increased libido
* Decreased libido
* Premature ejaculation
* Nocturnal emissions
* Sores on genitals
* Frequent urinary tract infections
* Chronic yeast infection

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

* Neck pain
* Upper back pain
* Lower back pain
* Hand/wrist pains
* Muscle pains
* Muscle weakness
* Cramps/spasms
* General joint pain/stiffness
* Shoulder pain
* Knee pain
* Foot/ankle pain
* Hip pain
* Joint with limited range of motion\_\_\_\_\_\_\_\_\_\_\_\_

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

* Seizures
* Loss of balance
* Areas of numbness
* Tics
* Lack of coordination
* Memory loss
* Concussion
* Depression
* Anxiety
* Irritability
* Easily susceptible to stress
* History of emotional/physical abuse

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses\_\_\_\_\_\_ If no longer menstruating, approximate date ceased\_\_\_\_\_\_\_\_\_\_\_\_

First day of last menses\_\_\_\_\_\_ Length between menses:\_\_\_\_\_\_days Duration of period:\_\_\_\_\_days

* Unusual flow (☐heavy or ☐light)
* Painful periods
* Irregular periods
* Clots in flow
* Vaginal discharge – color\_\_\_\_\_\_\_\_\_\_\_
* Vaginal odor
* Vaginal dryness
* Vaginal sores
* Hot flashes
* Breast lumps/soreness

Changes in body or psyche prior to menstruation (“PMS”):

Date of last PAP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results were: normal abnormal unsure

If you use birth control, what type & for how long?

Have you ever used hormonal methods for contraception or period regulation?

(i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

PREGNANCY HISTORY

Number of pregnancies\_\_\_\_\_\_ Births\_\_\_\_\_ Miscarriages\_\_\_\_\_\_ Abortions\_\_\_\_

Were your births relatively normal? Explain:

Other related concerns:

MUSCULOSKELETAL:

Utilized chiropractic care in the past?

Techniques used/technique preferences?

Any motor vehicle accidents?

Any radiology with significant findings? (x-rays, MRI, CT, etc)

**COMMENTS**

Please let us know of any other concerns you would like to address:

**Family History**: Please fill in the boxes for each condition that applies to one of your family members.

**Yes Who Comments**

|  |  |  |  |
| --- | --- | --- | --- |
| Addiction (alcohol/drugs) |  |  |  |
| Cancer |  |  |  |
| Cardiac disorders (heart disease, high blood pressure, stroke) |  |  |  |
| Diabetes |  |  |  |
| Digestive/Gastro-intestinal disorders |  |  |  |
| Immune disorders (hepatitis, HIV, etc.) |  |  |  |
| Mental illness |  |  |  |
| Respiratory disorders (asthma, allergies, etc) |  |  |  |
| Skin disorders (eczema, psoriasis, etc.) |  |  |  |
| Seizure disorders |  |  |  |
| OTHER |  |  |  |