



Name Date

ACUPUNCTURE INTAKE FORM

Please check all that apply in each category

PERSONAL HISTORY

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Bladder Disease |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Rectal Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Boils / Infection |
| <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Abuse | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Kidney Disease | |

Other Personal History Description:

FAMILY HISTORY

- | | | | |
|--|-------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> TB | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental Disorder | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | |

Other Family History Description:

HABITS

	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tea				
Tobacco				
Salt				
Sugar				
Diet				
Exercise				