Perreault Chiropractic

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Family Chiropractic **Acupuncture** **Automobile Injury**

Acupuncture Intake Form

Name: ______________________________________ Date: __________________________

Have you had acupuncture before? ☐ Yes ☐ No Do you bruise easily? ☐ Yes ☐ No

Do you have food cravings? Circle all that apply:

Sweet Salty Sour Bitter Spicy Dairy Carbs Meat Caffeine Other: _____________

Do you have any food intolerances/allergies? ____

Are you always thirsty? ________________ Do you prefer hot or cold to drink? ☐ Hot ☐ Cold

Do you perspire during the day? ☐ Yes ☐ No

Do you have any of the following? Circle all that apply:

Belching Nausea Vomiting Ulcers Bloating

Indigestion Hernia Hemorrhoids Acid Reflux

How often do you have a bowel movement? _____________ day/week

Do you have any of the following? Circle all that apply.

Irregularity w/Bowel Movements Constipation Diarrhea Gas Burning

How often do you urinate? _____________________ Color of urine? ___________________

Do you have? (Circle all that apply)

Day/Night Incontinence Burning Bladder Infections

What kind of exercise do you engage in? __________________ How often? _________________

How is your energy level? ____

How many hours of sleep do you get? __________ Do you perspire at night? _______________

Do you have? (Circle all that apply):

Difficulty falling asleep? Restlessness? Trouble staying asleep? Waking tired?

Do you have? (Circle all that apply)

Depression Anxiety Nervousness Fear Poor memory

Difficulty concentrating Shortness of breath Heart palpitations