Auburn Acupuncture

AUBURN ACUPUNCTURE INTAKE FORM

This information is confidential

Name: _____ Date: _____
Age: _____ Birth Date: _____ Sex: M / F
Married: ____ Divorced: ____ Single: ____ Other: ____
Street Address:_____
City: _____ Zip: _____
Phone: Home: _____ Work: _____ Cell: _____
Occupation & Employer: _____
How did you hear about Auburn Acupuncture?_____
Physician: _____ Physician Phone: _____
Emergency contact and phone number: _____
Email address: _____
Primary insurer's Name: _____
Birth Date: _____ Employer: _____

Have you ever had acupuncture? Y / N

What is your current concern? _____
_____ How Long? _____

What other treatments have you tried? _____
_____

Medications you are currently taking and for what conditions:
_____
_____
_____

Medical History (Check all that apply)

__ Aids/HIV	__ Diabetes	__ Emphysema	__ Multiple Sclerosis	__ Polio
__ Allergies	__ Cancer	__ Diabetes	__ Lyme Disease	__ Herpes
__ Heart Disease	__ Pacemaker	__ Seizures	__ Hepatitis A / B / C	
__ Tuberculosis	__ Varicose Veins	__ Alcoholism/Substance Abuse		

Other: _____

Surgeries:_____

Food Intolerances or allergies? _____

How many glasses do you drink of each of the following per day?

Water _____ Soda _____ Coffee _____ Tea _____ Alcohol _____

Gastrointestinal:

Do you currently have or have you had a major incidence in the past of:

__ Belching __ Indigestion __ Ulcers __ Bloating __ Acid Reflux

__ Hernia __ Nausea __ Vomiting __ Hemorrhoids

Exercise and Energy:

What kind of exercise do you do? _____ How often? _____

How is your general energy level? _____

Are you sedentary or active? _____

Emotions and Sleep:

__Panic Attacks __Depression Anxiety __Difficulty Concentrating

__Nervous __Fearful __Poor Memory

Gynecology:

Are you still menstruating? _____

If you have already gone thru menopause, what age? _____

How many days do you bleed? _____ How long is your cycle? _____

How many pregnancies/miscarriages? _____

__ Heavy flow __ Light flow __ No flow __ Normal

__ Blood clots __ PMS __ Painful periods

__ Uterine fibroids __ Cystic breasts

Respiratory:

Do you smoke? Y / N _____ times / day for _____ years

__ Frequent Colds __ Cold Sores __ Asthma __ Cough __ Dry Mouth __ Bleeding Gums

__ Ringing in Ears __ Ear pain __ Sinusitis __ Migraine __ Excessive Phlegm

Cardiovascular:

__ Palpitations __ Chest pain __ Irregular heart beat __ Varicose Veins __ Cold hands/feet

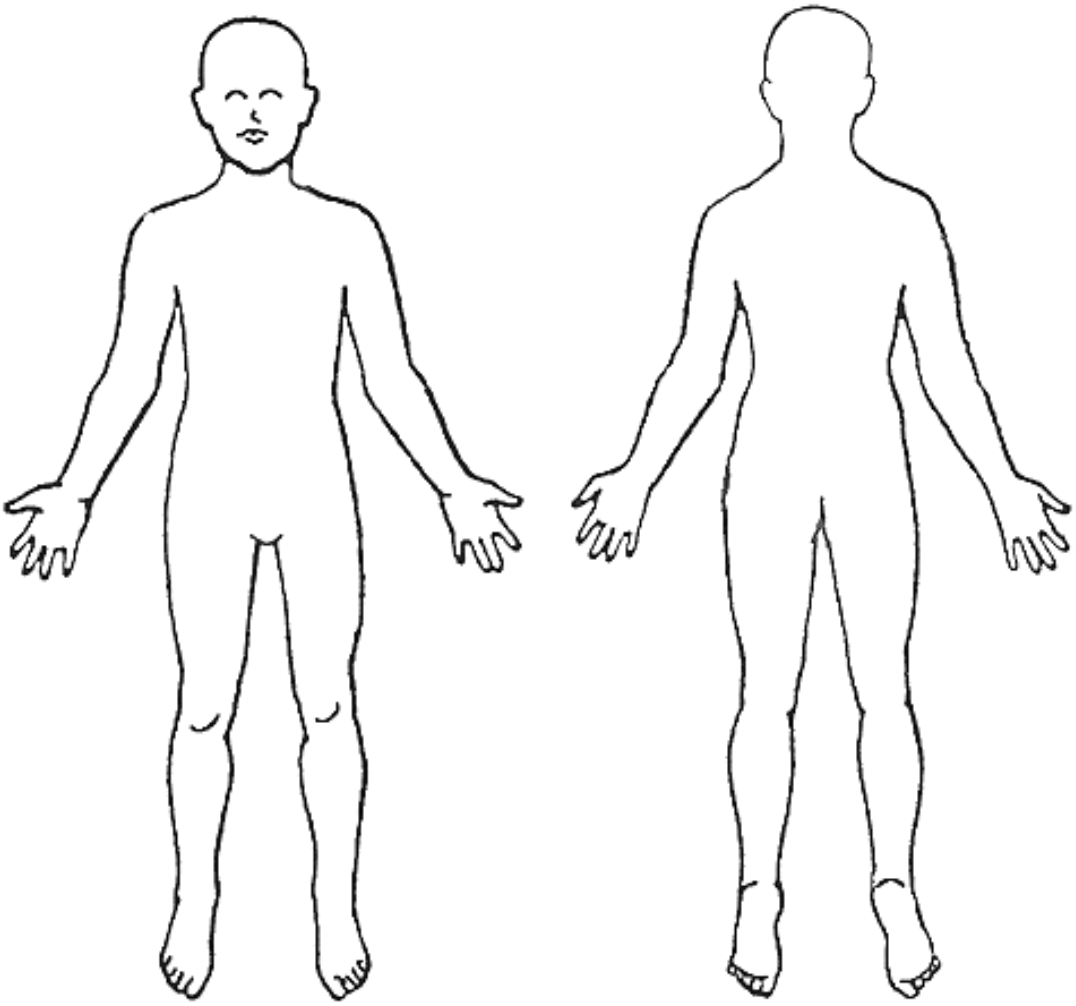
__ Poor circulation __ Dizziness __ High blood pressure __ Low blood pressure __ Blood clots

Musculoskeletal:

__ Joint pain __ Arthritis __ Numbness __ Muscle tightness

__ Tendonitis __ Osteoporosis __ Swelling __ Nerve Pain

Mark with an (X) where you are feeling any discomfort or pain.



If pain, please describe: Sharp Dull Stabbing Tight (please circle)

Do you have any additional health conditions or concerns?

_____

_____

_____

_____

Patient's Name

_____ _____

Signature of Patient or Legal Representative Date