

Creative Health

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Acupuncture Intake Form

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information:

Name: _____ Age: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

DOB: _____ If under 18, person responsible for your account: _____

Emergency Contact: _____ Contact Phone: _____

How did you hear about us? _____

Have you had acupuncture therapy before? YES NO With Whom? _____

Please indicate if any of the following pertain to you (marking "yes" does not make you ineligible for treatment; however, it may restrict some of our treatment modalities):

Hepatitis HIV High Blood Pressure Seizures Pacemaker Blood-thinning Meds Pregnancy

Please indicate the use and frequency of the following:

Coffee _____ Soda _____ Water _____

Alcohol _____ Rec. Drugs _____ Tobacco _____

Please list any prescriptions, herbs, over the counter medications you are presently taking:

Medication

Reason

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health History

What are the health concern(s) for which you are seeking treatment? _____

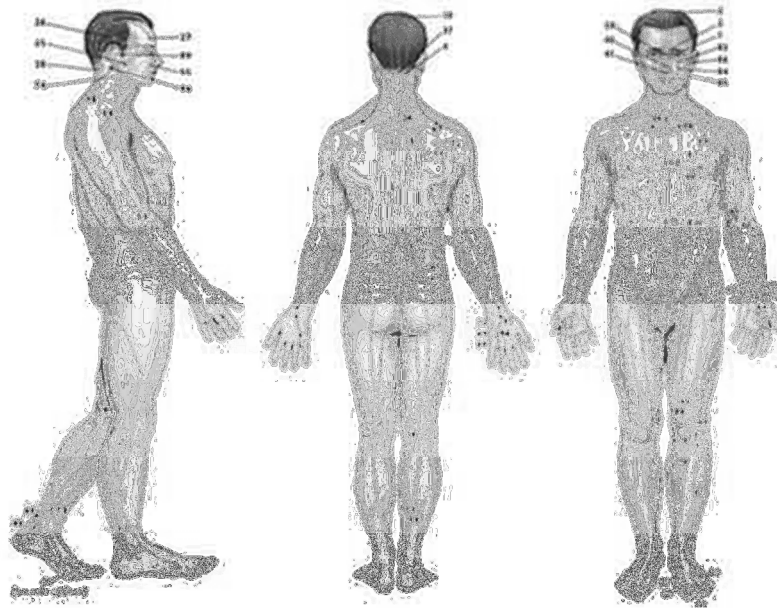
How long have you had this condition? _____

What other forms of treatment have you sought? _____

What aggravates your condition? _____

Please list any surgeries or major health incidents (accidents, etc.) in your life: _____

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain?

- Dull/Achy Sharp/Stabbing Burning Tingling Numbness Electrical

Symptom Survey

Please check the symptoms or conditions you experience frequently.

- | Sp/St | Ht/P | Lu/Li | Ki/UB | Liv/GB |
|---|---|--|--|--|
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cough | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Loose stool/diarrhea | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Knee problems | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Digestive problems, indigestion | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Decreased sense of smell | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Difficulty digesting oily foods |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Nasal problems | <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Gall stones |
| <input type="checkbox"/> Belching/burping | <input type="checkbox"/> Mentally restless | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Light colored stool |
| <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Laughing for no reason | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Soft/brittle nails |
| <input type="checkbox"/> Stomach bloating | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Colitis/diverticulitis | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Easily angered |
| <input type="checkbox"/> Obsession in work, relationships, etc. | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Constipation | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> sadness | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Easily bruised | <input type="checkbox"/> High cholesterol |
| | | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Bitter taste |
| | | <input type="checkbox"/> Recent use of antibiotics | | |

- Fatigue Edema Asthma Allergies Dizziness Get sick easily Headaches I usually feel warm I usually feel chilled

For Women Only:

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____ Number of days of flow _____

Color of flow: pale/light red red bright red dark red dark red/brown clots

Amount of flow: spotting light even throughout heavy

of pads you use per day? 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Pain and cramping: NO YES: __ Before flow __ During flow __ After flow __ Mild __ Moderate __ Severe

Other symptoms related to menses: Discharge PMS Headache Nausea Constipation Diarrhea

Swollen breasts Mood swings Increased appetite Decreased appetite Insomnia

Have you ever been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian cysts PID

Polycystic ovary syndrome STD _____