



## Acupuncture Intake Form

Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you

Date:				Referred by:			
First Name:		Last Name:		Cell Phone:		Work Phone:	
Height:	Height:	DOB:	Age:	Marital Status:	Occupation:		

Street:			City:		State:	Zip:
Emergency Contact:			Phone #:		Primary Care MD:	
Email address:				Best form of contact:		

Have you been treated by Acupuncture or Chinese Medicine before?
What is the main problem that brought you here today?
How long ago did this problem begin? Please be specific
Have you been given a diagnosis for this problem? If yes, what was the diagnosis and when was it given?
To what extent does this problem interfere with your daily activities, such as work, sleep, sex, etc.?
What treatments have you tried?

Surgeries		
Year	Reason	Outcome
Other hospitalizations		
Year	Reason	Outcome

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Medication	Strength	Frequency Taken	Comments

HEALTH HABITS AND PERSONAL SAFETY				
<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
<b>Diet</b>	Have you ever been on a restricted diet? If yes, what kind?			
	Please describe the average daily food intake:			
	Morning	Afternoon	Evening	Snacks:
<b>Water Intake</b>	How much water do you drink each day?			
<b>Caffeine</b>	<input type="checkbox"/> None	# of cups/cans per day:	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day

	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
<b>Sex</b>	Are you sexually active?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort or pain with intercourse?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>FAMILY HEALTH HISTORY</b>					

Please note the relationship to you of any of the following illnesses that apply to your family history:

- |                     |                       |
|---------------------|-----------------------|
| Relationship        | Relationship          |
| Cancer              | Chronic Lung Disease  |
| Tuberculosis        | Drug or Alcohol Abuse |
| Diabetes            | Mental Illness        |
| Heart Disease       | Leukemia              |
| High Blood Pressure | Migraine Headaches    |
| Low Blood Pressure  | Obesity               |
| Stroke              | Hypothyroid           |
| Epilepsy            | Hyperthyroid          |
| Allergies           | Ulcer                 |
| Asthma              | Depression/Anxiety    |
| Glaucoma            | High Cholesterol      |
| Gout                | Kidney Disease        |

	Present Age or Age at Death	Health (Good, Fair or Poor) If Deceased, cause of death		Present Age or Age at Death	Health (Good, Fair or Poor) If Deceased, cause of death
Father:			Children:		
Mother:					
Siblings:					

### Lifestyle Information

Occupational Stress (chemical, physical, psychological, etc.):

How does stress manifest for you (eg. insomnia, irritability, over-eating, etc.)?

Do you have a regular exercise program? If yes, please describe

### WOMEN'S HEALTH

Age at onset of Menstruation:

Date of last menstruation:

Period every \_\_\_\_ days

Age of Menopause:

Irregular Periods? If yes, please describe

Emotional changes with cycle? If yes, please describe

Color & Quality of Blood:

Light / Dark /Bright Red

Thick / Thin /Pasty

Menstrual Pain:

Sharp / Dull / Achy

Beginning / Middle / End of flow

Menstrual Clots: Size:

Color:

Beginning / Middle / End of flow

Unusual Periods:

Heavy / Light / Stop & Start

Other:

Spotting or pain between periods?

Yes  No

Sores on genitals?

Yes  No

Vaginal Discharge?

Clear/White/Yellow/Red

Thin/Thick/Cheese-like

Vaginal Itching?

Are you dealing with infertility issues at this time?

Yes  No

Have you tried Western Fertility treatments?

Yes  No

Number of pregnancies \_\_\_\_\_

Number of Premature  
births\_\_\_\_\_

Number of Miscarriages\_\_\_\_\_

Number of live births \_\_\_\_\_

Number Abortions\_\_\_\_\_

Date of Last Pap Smear:

Date of last Mammogram:

Results:

Results:

Breast Lumps?

Excessive bleeding or other issues with birth? If yes, please describe

Yes  No

### MENS HEALTH

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Impotence             | <input type="checkbox"/> Prostatitis     | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Low Sperm Count | <input type="checkbox"/> Spermatorrhea     |

Do you usually get up to urinate during the night? If yes, # of times _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

**General:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Fevers                    | <input type="checkbox"/> Poor Sleeping  | <input type="checkbox"/> Night Sweats       |
| <input type="checkbox"/> Sweat Easily              | <input type="checkbox"/> Chills         | <input type="checkbox"/> Cravings           |
| <input type="checkbox"/> Bleed or Bruise easily    | <input type="checkbox"/> Fatigue        | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Strong thirst: | <input type="checkbox"/> Weight gain        |
| <input type="checkbox"/> Sudden energy drop        | Hot/Cold/Room temperature               | <input type="checkbox"/> Weight loss        |

**Skin and Hair:**

- |                                   |                                       |                                  |
|-----------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Rashes   | <input type="checkbox"/> Ulcerations  | <input type="checkbox"/> Hives   |
| <input type="checkbox"/> Itching  | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/>         |

Recent Moles:

Change in hair or skin texture:

Any other hair or skin problems?

**Head, Eyes, Ears, Nose and Throat:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Glasses         | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Concussions    | <input type="checkbox"/> Cataracts       | <input type="checkbox"/>                        |
| Dates:                                  | Diagnosis date:                          | <input type="checkbox"/> Poor hearing           |
| <input type="checkbox"/> Nose Bleeds    | <input type="checkbox"/> Poor vision     | <input type="checkbox"/> Ringing in ears:       |
| <input type="checkbox"/> Facial pain    | <input type="checkbox"/> Eye strain      | High pitch/Low pitch                            |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Earaches               |
| <input type="checkbox"/> Jaw clicks     | <input type="checkbox"/> Blurry vision   | <input type="checkbox"/>                        |

<input type="checkbox"/> Migraines	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Recurrent sore throats
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Color blindness	<input type="checkbox"/> Sores on lips or tongue
Headaches:		
Teeth problems:		
Any other head or neck problems?		
<b>Cardiovascular:</b>		
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Swelling of feet	<input type="checkbox"/> Difficulty in breathing
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Cold hands and feet	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Fainting	<input type="checkbox"/> Phlebitis	<input type="checkbox"/>
Any other heart or blood vessel problems?		
<b>Respiratory:</b>		
<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pain with a deep breath
Difficulty breathing when lying down?		
Production of phlegm? If yes, what color?		
Any other lung problems?		
<b>Gastrointestinal:</b>		
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation	<input type="checkbox"/> Gas	<input type="checkbox"/> Belching
<input type="checkbox"/> Black stools	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Rectal pain	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Abdominal pain or cramps	<input type="checkbox"/> Chronic laxative use	<input type="checkbox"/> Poor appetite
Any other problems with your stomach or intestines?		

<b>Genito-Urinary:</b>		
<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> How many times per day do you urinate?	<input type="checkbox"/> Pain w/urination
<input type="checkbox"/> Unable to hold urine		<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Decrease in urine flow	<input type="checkbox"/> Do you wake to urinate? How often?	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Color to urine? White/Yellow/Clear/Cloudy		<input type="checkbox"/> Sores on genitals: How often?

Any other problems with your genital or urinary system?		
<b>Musculoskeletal:</b>		
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Knee pain
<input type="checkbox"/> Back pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Foot/Ankle pain
<input type="checkbox"/> Hand/Wrist pain	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Hip pain
Any other joint or bone problem?		
<b>Neuropsychological:</b>		
<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression	<input type="checkbox"/> Lack of coordination
<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Easily angered	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Tremors	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Poor memory
<input type="checkbox"/> Fearful	<input type="checkbox"/> Easily susceptible to stress	<input type="checkbox"/> Sadness
Have you ever been treated for emotional problems?		
Have you ever considered suicide?		
Have you ever attempted suicide?		
Any other neuropsychological problems?		

Is there anything else you would like to discuss?
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- Have you had a fever in the last 24 hours of 100°F or above?
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?
- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?

I understand that, because acupuncture work involves touch and close physical proximity, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this practitioner. Please be prepared to let us know at the beginning of your session what you would like to have addressed in your body work treatment.

I further acknowledge that I am voluntarily participating in the above referenced activities with the full knowledge and understanding that said activities are taking place during the COVID-19 pandemic. I understand that while Synergy Wellness Center LLC and its employees and contractors will abide by all local, state, and federal government laws and guidelines, as well as CDC guidelines, in an attempt to keep employees and patients safe, that I assume ALL risks associated with participation in said activities during said pandemic, including but not limited to: any illness and any adverse physical and/or psychological effects from the same and/or loss of any income or other monetary loss incurred as a result of the effects of said illness and/or costs incurred in the treatment of the same. I accept full and total responsibility for my own health and agree to release, hold harmless, and indemnify, to the extent permitted by the law, Synergy Wellness Center LLC, its employees and contractors from any liability for any illness, injury, loss or damages I may incur as a result of contracting COVID-19 as a result of engaging in said above referenced activities.

I have read, understand, and agree to the content of this Agreement and voluntarily agree to the terms and conditions stated above.

\_\_\_\_\_  
Signature (must be over age 18)

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
Legal Guardian (for youth under age 18)

\_\_\_\_\_  
Date