Wendy Swanson L.Ac, MS, MBA Date ____/_____/_____

Acupuncture Intake Form (please print)

Note: Information provided on this form is confidential

Please fill out as completely as possible.

How did you hear about us? _____

Name _____Date of Birth ___/___/___ Age: __ Sex: M □ F□

Address_____

_____

Email Address: _____

Telephone (home) _____ (work) _____ (cell) _____

What number do you prefer to be called on? _____

Can we leave a message? _____

Emergency Contact Person_____

Relationship_____Tel:_____

Physician_____ Physician's phone # _____

Occupation_____

What do want treated with acupuncture? _____

_____

_____

Have you received a medical diagnosis for this condition and if so what is it? _____

_____

_____

What other treatments have you received for this condition? _____

_____

What medications are you taking? REASON for taking?

_____

_____

_____

_____

_____

What vitamins or other supplements are you taking? REASON for taking?

_____

_____

_____

Is this your first experience with acupuncture? _____

How do you feel about acupuncture? _____

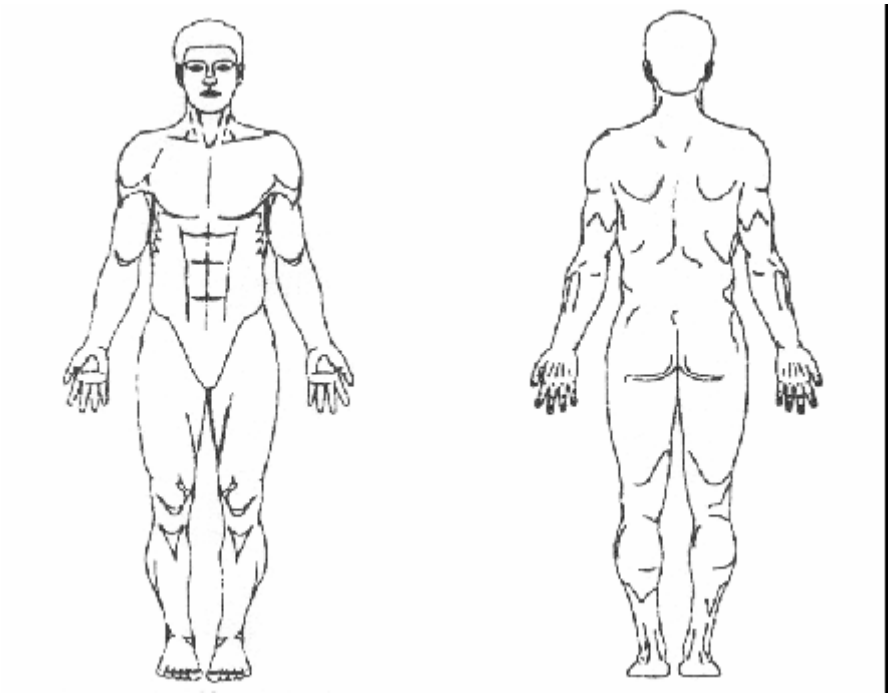
_____

Are you currently pregnant? Yes □ No

Are you presently trying to get pregnant? Yes □ No □

On the following drawings, shade in the areas where you feel should be addressed.

Comments:



Past Medical History:

Have you had any of this condition(s)? Check all that apply:

□ AIDS/HIV	□ Lyme's Disease
□ Alcoholism	□ Lymph Nodes removed
□ Allergies: If so what are they?	□ Multiple Sclerosis
□ Asthma	□ Pacemaker
□ Birth Trauma	□ Polio
□ Cancer	□ Rheumatic Fever
□ Diabetes	□ Scarlet Fever
□ Drug Addictions	□ Seasonal Allergies
□ Emphysema	□ Seizures
□ Fibromyalgia	□ Sinus Infections
□ Heart Disease	□ Tuberculosis
□ Hepatitis (Which one?)	□ Operations: (for what?)
□ Herpes	
□ Joint Replacements	□ Other:

(Check all that apply currently/ Underline all that applied in the past)

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis, etc…..)
Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Exercise & Energy:
How is your energy? _____
What time of day is your energy the highest? _____Lowest? _____
Do you fatigue easily? _____
What kind of exercise do you do? _____
How often do you exercise? _____

Emotions & Sleep:
How do you feel emotionally? _____
Do you have (check for present/ underline for past): Panic attacks □ Depression □ Anxiety □
Bad temper □ Nervousness □ Fear attacks □ Poor memory □ Difficult concentration □
Are you in a relationship? Yes □ No □
How do you feel about your relationship? _____
How do you hold stress? _____
How do you relax? _____
How do you feel about your work? _____
How long do you normally sleep? _____hours per night
I have difficulties with: Falling asleep □ Staying asleep □ Dream-disturbed sleep □ Waking up at about _____am/pm and not being able to fall asleep again □

Tobacco, Food and Drink Habits:
Do you smoke? No □ Yes □ _____per day, for _____years
Smoke previously? No □ Yes □ _____per day, for _____years
Ever been treated for drug dependence? No □ Yes □
Drink Alcohol? No □ Yes □ How much? _____
Drink Caffeinated Beverages? No □ Yes □ How much? _____
Eat out often? No □ Yes □ How many times per week? _____
How many meals do you eat per day? _____
Go on diets often? No □ Yes □

Typical Food Intake:
Breakfast_____
Lunch_____
Dinner_____
Snacks: _____

Any History of Psychological, Physical or Sexual Abuse that I should be aware of?
No □ Yes □

(Check all that apply currently/ Underline all that applied in the past)

Gastrointestinal:
I have (check for present/ underline for past): Belching □ Nausea □ Vomiting □ Vomiting of blood □ Ulcers □ Bloating □ Acid regurgitation □ Heartburn □ Hernia □ Indigestion □ Severe stomach pain □

Bowel movements: How often? _____time(s)/day _____days/week

I have (check for present/ underline for past): Irregular □ Constipation □ Diarrhea □ Gas □ Burning sensation □ Hemorrhoids □ Undigested food in stool □ Loose stool □ Hard stool □ Blood in stool □ Itchiness □ Painful bowel movements □

Urinary:
Urination: How often? _____ (times per day)
Color: Pale yellow □ Dark yellow/orange □

I have or had (check for present/ underline for past): Trouble starting stream □ Frequent urination □ Incontinence □ Pain □ Burning □ Dribbling when sneezing □ Blood in urine□ Kidney stones □ Urinary tract infections □
Other_____

Women:
At what age did you start menstruating? _____ Number of days between cycles: _____
Number of days of flow: _____ Color: _____

I have or had (check for present/ underline for past): Irregular menstruation □ Heavy flow □ Light flow □ No flow □ Clots □ Spotting between periods □

Discomfort/pain before period □ Discomfort/pain during period □ PMS mood swings □

Breast Lumps □ Nipple Discharge □ Breast Pain or Tenderness □
Fibroids □ Ovarian Cysts □ Sexual Difficulties □

Vaginal itching/burning □ Vaginal discharge? No □ Yes □ Color_____

Menopausal Symptoms No □ Yes □ What: _____

Number of Pregnancies: _____ Number of Miscarriages: _____ Number of Abortions: _____

Men:
I have (check for present/ underline for past): Prostate Disease □ Impotence □ Testicular Pain □ Testicular Masses □ Premature Ejaculation □ Hernias □
Other: _____

(Check all that apply currently/ Underline all that applied in the past)

Muscles, Joints & Bones:
Do you have pain or tightness? No □ Yes □
Where? _____

The pain is: Sharp □ Dull □ Aching □ Numb □ Superficial Pain □ Deep Pain □
Burning □ Tingling □ Shooting □ Pain worse/better with heat □ Pain worse/better with cold □
Pain worse/better with pressure □ Pain worse in am □ Pain worse in pm □

I have: Swollen joints □ Arthritis/joint pain □ Tendonitis □ Bone pain □ Muscle cramping □
Muscle pain □ Repetitive Strain Injury □ Fractured Bone(s) □

Where?_____
Other_____

Eyes, Ears, Nose, Throat, & Head:
I have (check for present/ underline for past): Frequent colds □ Chronic runny nose □
Frequent sore throat □ Chronic cough □ Coughing blood □ Cough up mucous □ Pain inhaling
□ Shortness of breath on exertion/at rest □ Asthma □ Nose bleeds □ Painful/red eyes □ Poor vision □ See spots/floaters □ Dizziness □ Cold sores □ Bleeding gums □ Dry mouth □ Ear pain □ Ringing in ears □ Clogged/popping in ears □

Frequent headaches/migraines □ describe: _____

Cardiovascular:
I have (check for present/ underline for past): Chest pain □ Palpitation □ Varicose veins □
Phlebitis □ Cold hands and feet □ Irregular heart beat □ Poor circulation □
Other:_____

Skin & Hair:
I have or often have (check for present/ underline for past): Dry skin □ Skin rashes □ Itching □
Acne □ Eczema □ Hives □ Hair loss □ Premature graying □
Other:_____

Thank you for filling this form out completely!