

Indy Acupuncture & Health Services Intake Form

Name: _____ Birthdate: _____
Address: _____ Age: _____

Gender: Male Female
Phones: _____ Occupation: _____
E-mail: _____ Receive seasonal e-newsletter: Yes No

Your emergency contact and phone number: _____

Your physician name and date of last check-up: _____

How did you hear about indy acupuncture? _____

What is your chief complaint? _____

Where is the location of the problem? _____

When did this problem begin? _____

Is it constant, or does it come and go? _____

Is it related to circumstance or position? _____

If your problem is pain related, how would you describe it? (sharp, dull, numb, etc.) _____

How would you rate the problem on a scale of 1-10? (1 = best, 10 = worst) _____

Have you found anything to aggravate the condition? _____

Have you found anything to relieve the condition? _____

What prior treatments have you tried for the condition? _____

Do you have a 2nd chief complaint? Yes No If so, what? _____

History:

Any major surgeries? _____ Hospitalizations? _____

If so, when? _____

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Any allergies? Yes No If so, to what? _____

Any genetic problems? Yes No If so, what? _____

Lifestyle:

Please indicate whether you participate in the following, and if so, the amount of participation.

Exercise: Yes No If so, how much? _____

Alcohol: Yes No If so, how much? _____

Cigarettes: Yes No If so, how much? _____

Recreational drugs: Yes No If so, how much? _____

Other: _____

Medications / Supplements / Herbs:

List any medications / supplements / herbs you are taking currently. Also, please list how long you have been taking them and who prescribed them to you: _____

Other questions to get a holistic picture: (no need to answer questions that deal with your chief complaints. No need to answer questions not applicable to you.)

How is your energy on a 1 – 10 scale? _____ Any shortness of breath? Yes No

Trouble falling or staying asleep? Yes No How many times do you wake throughout the night? _____

How would you rate your diet? (1 = poor, 10 = very healthy) _____

Do you have high blood pressure or cholesterol? _____

Any strong cravings? Yes No Any digestive troubles? Yes No

How often do you have bowel movements? _____ Are they normal, too hard or loose? _____

Any urinary troubles? Yes No Amount: *(Frequent, too much, too little, etc.)* _____

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How much water do you drink per day? _____

Do you tend to feel hot or cold? _____ Just hands & feet or all over? _____

Any unusual sweating? Yes No Daytime or nighttime? _____ Or not enough? _____

Any pains? Yes No If so, describe where? _____

Any emotional issues you want to address? (*depression, anxiety, grief, anger, irritability, sadness, worry, indecision, etc.*) Yes No

Please describe emotional issues if applicable: _____

Any problems with the Head? (*eyes, ears, nose, throat, sinus, headaches*) Yes No If so, what? _____

For Women:

At what age was your first period? _____ Is your cycle regular or irregular? _____

How many days between periods? (*from the first day of your period, to the next first day*) _____

How many days do you bleed? _____ Is it heavy or light or normal? _____

Do you notice clots? Yes No Do you get cramps? Yes No

If cramping, when are they most common? (*before, during, or after period*) _____

How would you describe the pain? (*sharp, dull, achy, stabbing, bloating, back pain, etc.*) _____

Are you pregnant? Yes No How many births? _____ Miscarriages? _____ Abortions? _____

Any Gynecological Diagnosis? Yes No If so, what? _____

For Men:

Any prostate or genital problems? Yes No If so, what? _____

Further notes: _____