ACUPUNCTURE INTAKE FORM

Please Print

Name: _____ Date of birth (dav/month/yr): _____
Address: _____ Zip Code: _____
Telephone: Home # _____ Work # _____ Cell # _____
Occupation; _____ Email Address: _____
Name of primary health care physician and date of last exam: _____
How did you learn about CCWC ? _____
Emergency Contact Name: _____ Phone: _____

Briefly describe condition(s) requiring attention:

_____

Medications (inc. vitamins, herbs): _____

Family Medical History (diabetes, cancer...etc): _____

Medical History – Mark any condition you previously had with an X or currently have with a /

- ❑ Allergies, sensitivity (specify)_____
- ❑ Asthma
- ❑ Respiratory problems
- ❑ Sinus problems
- ❑ Abnormal skin conditions
- ❑ Elimination problems
- ❑ Hemorrhoids
- ❑ Crohn's disease

- ❑ Digestive complaints
- ❑ Food cravings (specify) _____
- ❑ Feeling of heaviness in body
- ❑ Mental fatigue
- ❑ Varicose veins
- ❑ Bruise easily

- ❑ Heart problems (specify) _____
- ❑ Low Blood Pressure
- ❑ Palpitations
- ❑ Insomnia, difficulty falling asleep
- ❑ Dream disturbed sleep
- ❑ Anxiety
- ❑ Distention in lower abdomen

- ❑ Low back and/or knee pain
- ❑ Osteoporosis
- ❑ Urinary problems and/or infections
- ❑ Phobias/ Fears
- ❑ Nervous problems
- ❑ Ear problems
- ❑ Wake up many times at night
- ❑ Sexual/reproductive dysfunction

- ❑ Swollen lymphatic glands
- ❑ Hypersensitivity
- ❑ Rashes/ hives
- ❑ Nervous in social situations
- ❑ Swelling or chilling of extremities
- ❑ Circulatory problems

- ❑ High Blood Pressure
- ❑ Dizziness
- ❑ Anger /irritability
- ❑ Stiff joints
- ❑ Jaundice
- ❑ Sore eyes
- ❑ Brittle nails
- ❑ Wake up early then fall asleep again

- ❑ Anemia
- ❑ Candida
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Diabetes

Females :
- ❑ Menstrual Problems (specify eg. cramps) _____
- ❑ Pregnancy
- ❑ Menopause

- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Arthritis (specify)_____
- ❑ Headaches, migraines
- ❑ Mental health issue (specify)_____
- ❑ MS

- ❑ Tendonitis (specify) _____
- ❑ Sprains/strains _____
- ❑ Recent injuries _____

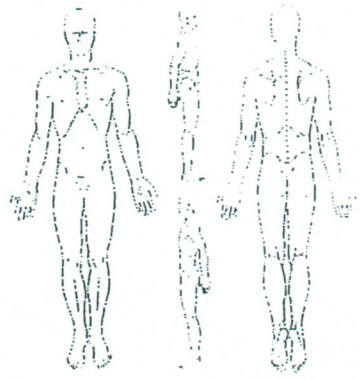
Major Trauma (auto, fall, etc): _____

_____

Surgery (type/date):

_____

Please Indicate area requiring attention using the following legend XX pain ≡ numb ///stiff



Questions you may have:

_____

_____

_____

_____

_____

Filled out by the Therapist

C/C-

Relieving-
Exacerbating-

Hot/Cold-

Sweat-

Appetite/Thirst-

Stool/Urine-

Sleep-

Emotions-

Energy-

Stress-

Diet/alcohol/drugs/smolking-

Exercise-

Menstruation/Pregnancy/Children-

Observation-

T-

P-

Dx-

Px-