ACUPUNCTURE THERAPEUTICS INTAKE FORM

Date of Evaluation ____/____/____

Name (first/middle initial/last) _____Age ____ D.O.B. ____/____/____

Referring Physician_____Family Physician_____

Occupation _____Work related? ___Yes ___No.

Auto related? ___Yes, State _____ ___No

Leisure Activities

_____

How did you hear about us? ___Physician ___Family ___Friend Other _____

1. What problems or concerns would you like addressed? Explain:

_____-

_____

2. When did your main problem develop? (exact date) ____/____/____

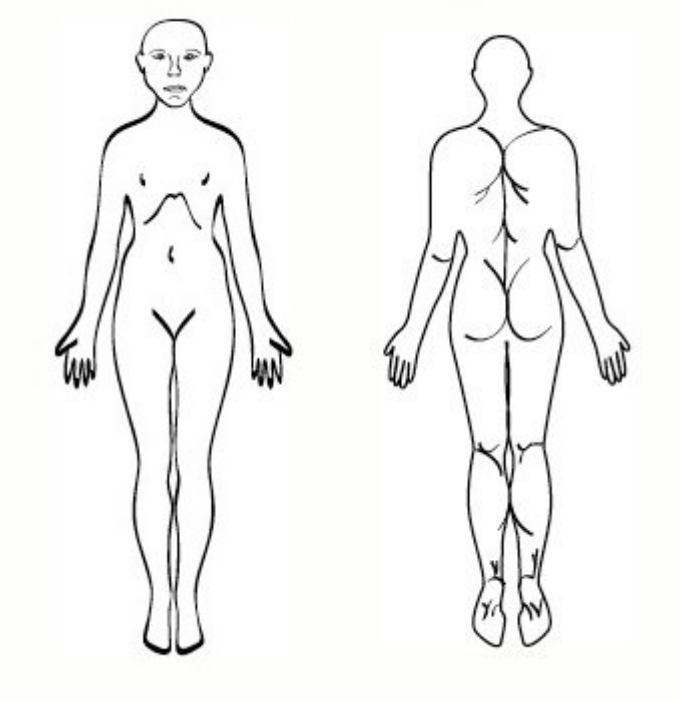
3. How did your problem begin?

_____

4. Since your problem began, is it? __Improving __Staying the same __ Worsening

5. Please note on the diagram where you're experiencing pain (using the appropriate letters)

T = Tingling,/ **D = Dull**,/ **S = Sharp**,/ **N = Numbness**,/ **B = Burning**,/ **R = Radiating**,/ **A = Ache**



6. Is your pain?
___Constant ___Intermittent

7. Express your pain on a scale of 0-10 (10 being extreme):
_____ At present _____ At best _____ At worst

8. Are there any activities or positions that significantly worsen your symptoms?
___Sitting ___Standing ___Walking ___Lifting ___Lying down ___ Ice ___Heat __Coughing/Sneezing
___ Bending ___Bowel or bladder movements ___Other_____

9. Are there any activities or positions that significantly improve your symptoms?
___ Sitting ___ Standing ___ Walking ___ Lifting ___ Lying down ___ Ice ___ Heat ___ Pain medications
___ Bending ___ Other _____

10. What part of the day do you feel best? _____Worst? _____

11. Is sleep disturbed due to your pain? __Yes __No.

12. Do you wake up at night due to pain? __yes __No

13. Are you currently receiving the following treatment with another provider?
___ Physical Therapy ___ Chiropractic ___ Massage ___ Home Healthcare Services ___ Skilled Nursing Facility Services __Other:_____

14. Have you had prior treatment(s) for this condition?
___ Physical Therapy ___ Chiropractic ___ Injections ___ Massage ___ Surgery ____ Acupuncture
✿✿Other:_____

15. Recent diagnostic tests? ___ X-ray ___ CT Scan ___ MRI ___ EMG ___ Bone Scan ___ Other:_____

16. Please list all medications you are currently taking, (and what they are for)

---

17. Have you ever had any of the following? (Please check all that apply.)

__Anxiety disorder
__ Arthritis
__ Asthma
__ Bladder problems
__ Blood clots
__ Bowel problems
__ Breathing problems
__ Broken bones
__Cancer
__Chills
__Circulatory problems
_✿Depression
__Diabetes
__Dizziness
__Easy bleeding
__Easy bruising
__ Elective surgery
__Emphysema
__Fatigue
__Fever
__Head injury
__Headaches/ Migrains
__Heart problems/Heart attack
__Hernia
__High blood pressure
__HIV/AIDS
__Kidney problems
__Liver/Gallbladder
__Major trauma
__Metal implants
__Nausea
__Osteoporosis
__Pacemaker
__Pregnancy, _past,_ present
__Rheumatoid
__Ringing in ears
__Seizures
__Shingles
__Skin problems
__Sleeping problems
__Smoking _past _ present
__Strokes
__Sweating
__Ulcers
__Vomiting
__Weakness__
__Weight loss/ Weight gain

__(women) menstrual problems/ ovarian problem

__(women) hormonal changes menopause sx

Please explain any checked items above and add others not listed:

_____
_____
_____
_____

17. Past surgical history and diagnoses:

_____

I have Provided correct and complete information to the best of my knowledge. I agree to notify the Acupuncturist immediately whenever I have changes in my health condition.

I understand that all payments are due at the time of treatment. (If my insurance company covers Acupuncture: I will be provided with a receipt, upon request, with all pertinent information so that I can submit it to my insurance company for direct reimbursement.)

I understand that I personally am responsible for any missed appointments unless I cancel them at least 24 hrs in advance of treatment, unless other arrangements has been made.

I understand that my session will end promptly as scheduled, due to respect for the next patient's time. If I am late, I will be responsible for the full fee of the session.

Patients signature;_____ Date:_____

Print name:_____