HEALTH + WELLNESS

equilibrium

Acupuncture Intake Form

How did you hear about us? ☐ Family/Friend ☐ Doctor Referral ☐ Internet ☐ Insurance ☐ Social Media ☐ ZocDoc

PERSONAL INFORMATION

Name: _____

Date of Birth: _____ / _____ /_____ Social Security Number: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

PRIMARY PHONE to receive a call or message: (_____) _____-_____

Email Address: _____

EMERGENCY CONTACT

Name: _____ Contact number for this person: (_____) _____-_____

MAIN COMPLAINT

_____

How long have you had this problem? _____

My symptoms are ☐ Severe ☐ Moderate ☐ Mild | My symptoms are ☐ Improving ☐ Worsening ☐ Unchanged

What has/seems to cause this problem? _____

What makes your symptoms improve? _____

What makes your symptoms worse? _____

Do your symptoms affect your daily activities? ☐ Yes ☐ No If so, please describe:_____

Have you received a medical diagnosis? ☐ Yes ☐ No If so, please list:_____

What are you hoping to achieve with treatment?)_____

_____

Medications taken in the last 3 months, including over-the-counter medications.
Please include any vitamins, supplements, or herbal medicine(s) you are taking.

Medication/Supplement	Dosage	For what condition?	How long have you been taking this?

Please list any allergies or adverse reactions, especially related to food and/or drugs.

_____

_____

PERSONAL/SOCIAL HISTORY

Please indicate the use and frequency of the following:

Cigarettes ☐ YES ☐ NO How many per day? _____ Since when? _____

Alcohol ☐ YES ☐ NO Amount? _____

Recreational drugs ☐ YES ☐ NO Type? _____ Amount? _____

Coffee ☐ YES ☐ NO Amount? _____ **Soda** ☐ YES ☐ NO Amount? _____ **Water** ☐ YES ☐ NO Amount? _____

Please describe average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

How do you feel about the following areas of your life?

	GREAT	GOOD	FAIR	POOR	BAD	N/A	COMMENTS
Significant Other	☐	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	☐	_____

Please check any of the following that apply to you now or in the past three months

Psycho Emotional

☐ ***I DENY having any of the symptoms listed below***

☐ easily stressed	☐ panic attacks	☐ difficulty sleeping	☐ addiction	☐ suicidal attempts/thoughts
☐ irritability	☐ anxiety	☐ racing thoughts	☐ substance abuse	☐ seeing a therapist
☐ mood changes	☐ depression	☐ foggy head	☐ disordered eating	☐ other

Skin and Hair

☐ ***I DENY having any of the symptoms listed below***

☐ rashes/hives	☐ psoriasis	☐ itching	☐ hair loss	☐ easy bruising
☐ eczema	☐ dry skin	☐ pimples/acne	☐ tumors/lumps/cysts	☐ other

Head, Eyes, Ears, Nose & Throat

☐ ***I DENY having any of the symptoms listed below***

☐ vision changes	☐ ringing in ears	☐ sinus problems	☐ dizziness	☐ teeth/gum problems
☐ spots in the eyes	☐ clogged ears	☐ loss of taste/smell	☐ headache	☐ grinding/clenching teeth
☐ dry eyes	☐ ear pain	☐ nosebleeds	☐ migraine	☐ jaw clicks/pops
☐ blurry vision	☐ poor hearing	☐ runny nose	☐ concussion	☐ facial pain
☐ allergies		☐ congestion		☐ other

Cardiovascular

☐ ***I DENY having any of the symptoms listed below***

☐ high blood pressure	☐ irregular heartbeat	☐ swelling	☐ anemia	☐ hot/cold intolerance
☐ low blood pressure	☐ chest pain	☐ night sweats	☐ blood clots	☐ cold hands/feet
☐ fainting	☐ palpitations	☐ sweat easily	☐ poor circulation	☐ other

Respiratory

☐ ***I DENY having any of the symptoms listed below***

☐ pain with deep breath	☐ coughing/wheezing	☐ difficulty breathing	☐ emphysema	☐ frequent colds/flu
☐ chest tightness	☐ asthma	☐ sleep apnea	☐ bronchitis	☐ other

Gastrointestinal

☐ ***I DENY having any of the symptoms listed below***

☐ weight gain	☐ rectal pain/burning	☐ food cravings	☐ loose stools	☐ nausea/vomiting
☐ weight loss	☐ incomplete defecation	☐ gas/bloating	☐ food in stool	☐ acid reflux/heartburn
☐ poor appetite	☐ chronic laxative use	☐ indigestion	☐ diarrhea	☐ hiatal hernia
☐ excess appetite	☐ constipation	☐ belching	☐ blood in stool	☐ bad breath
☐ strong thirst	☐ hemorrhoids	☐ foul smelling stools	☐ abdominal pain	☐ other

Genito-Urinary

☐ ***I DENY having any of the symptoms listed below***

☐ urgency to urinate	☐ nighttime urination	☐ pain on urination	☐ burning urination	☐ genital itching
☐ incomplete urination	☐ dribbling urine	☐ blood in urine	☐ cloudy urine	☐ STDs
☐ decreased urine flow	☐ decreased libido	☐ kidney stones	☐ frequent UTIs	☐ other

Musculoskeletal/Neurological

☐ ***I DENY having any of the symptoms listed below***

☐ neck tightness/pain	☐ knee pain	☐ disc herniation/bulge	☐ poor coordination	☐ heavy body sensation
☐ shoulder pain	☐ hip pain	☐ tingling/numbness	☐ seizures	☐ muscle weakness
☐ hand/wrist pain	☐ back pain	☐ scoliosis	☐ tremors	☐ other
☐ sprain	☐ arthritis	☐ paralysis		

Gynecological ☐ ***I DENY having any of the symptoms listed below***

If you have already had menopause, please describe your past menstruation

Menstruation

Age of first period _____ Start date of most recent period _____

Length of average menstrual cycle (from start of one period to the next) _____ Number of days of flow _____

Color	☐ bright red	☐ dark red	☐ pale	☐ brown	
Consistency	☐ thick	☐ watery	☐ clots	☐ mucousy	
Flow	☐ very heavy	☐ heavy	☐ moderate	☐ light	☐ spotting only
Menstrual cramps	☐ none	☐ before period	☐ during period	☐ after period	☐ at ovulation (mid-cycle)
Headaches	☐ none	☐ before period	☐ during period	☐ after period	☐ at ovulation (mid-cycle)
Other _____	☐ none	☐ before period	☐ during period	☐ after period	☐ at ovulation (mid-cycle)

Gynecological conditions

☐ fibroids	☐ polyps	☐ endometriosis	☐ mastitis	☐ abnormal paps	☐ yeast infections
☐ cysts	☐ PCOS	☐ bacterial vaginosis	☐ breast lumps	☐ PID	☐ other

Hormonal Birth Control

☐ N/A ☐ Oral (pill) ☐ IUD ☐ Patch ☐ Nuvaring ☐ Intradermal ☐ Injection **For how long?** _____

Pregnancy

Is there a possibility that you are pregnant ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

pregnancies _____ # live births _____ # miscarriages _____ # abortions _____ # premature births _____

Menopause

Age of onset of menopause _____

Current symptoms ☐ hot flashes ☐ night sweats ☐ irritability ☐ difficulty sleeping ☐ other_____

Please describe any other issues you would like to discuss.

_____

_____

_____

_____

_____

_____

_____

The information on this form is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____