

ACUPUNCTURE INTAKE – CENTER FOR LIVING

| Please print and complete <u>ALL</u> questions. | |
|--|---|
| Name: | Date: |
| Address: | Phone: |
| | Phone-Eve: |
| City: | St:Zip: |
| Date of birth:Age:En | nail: |
| Primary health care provider: | |
| Telephone: | Address: |
| Emergency contact: | Contact #: |
| - | e treatment? |
| Main complaint(s) or purpose for visit: | |
| I: | |
| | |
| III: | |
| | ssions? |
| | |
| Are you currently being treated by other medical p | ractitioners? |
| Acupuncture/massage may bring up emotional issu process. | ues, and is often used in conjunction with psychotherapy to enhance the |
| Are you currently seeing a psychotherapist or are y Yes No If Yes, please explain: | ou attending regular support group meetings? |
| List stress reduction and exercise activities. Include | e frequency: |
| List current medications, including aspirin, ibuprot | fen, herbs or supplements, etc.: |
| List previous surgeries and/or physical injuries (inc | clude year and treatment): |

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NNYACUPNCT

| Page 2 Client Name: | MUSCULO-SKELETAL |
|-----------------------------|---|
| SKIN | □ bone/joint disease |
| □ allergies | ☐ tendonitis |
| anergies | ☐ bursitis |
| athletes' foot | ☐ broken or fractured bones |
| warts | arthritis |
| other | ☐ jaw pain/TMJ dysfunction |
| DIGESTIVE | □ sprains/strains □ low back, hip, leg pain |
| | neck, shoulder, arm pain |
| constipation | headaches/head injuries |
| gas/bloating diverticulitis | spasms/cramps |
| ☐ irritable bowel syndrome | upus |
| other | other |
| NERVOUS SYSTEM | CIRCULATORY |
| ☐ herpes/shingles | heart condition |
| unumbness/tingling | □ varicose veins |
| chronic pain | □ blood clots |
| ☐ fatigue | ☐ high blood pressure |
| ☐ sleep disorders | low blood pressure |
| other | ☐ lymphedema |
| | □ breathing difficulty |
| OTHER | sinus problems |
| ancer/tumors | □ allergies |
| diabetes | other |
| • eating disorders | INFECTIOUS DISEASE |
| depression | () disease name(s): |
| ☐ drug/alcohol addiction | disease name(s): |
| incotine/carreine addiction | |
| Please indicate the area o | f pain on the figures below: |
| Patient Signature: | Date: Time: |