SYMMETRY ACUPUNCTURE

Intake Form

Name

_____

Address

_____

Telephone
Day _____ Evening _____ Cell _____

Email _____

Date of birth _____ Age _____
Height _____ Weight _____

Occupation _____

Employer Name & Address

_____

Emergency Contact

_____

Phone & relationship to you: _____

Primary Care Doctor (Name & contact)

_____

How did you hear about us?

_____

Have you **ever had acupuncture**? Y / N

What is your **current concern**?

_____
_____
_____
_____
_____

How long have you been dealing with this concern? _____

What **other treatments** have you tried? _____
_____

What **medications** and/or **supplements** you are currently taking? For what conditions?_____
_____
_____
_____
_____

Medical History:
(Check all that apply)
__ Aids/HIV __Alcoholism/Substance Abuse
__Allergies to Latex __Hepatitis A / B / C
__Bleeding Disorder __Herpes
__Cancer __Edema
__Emphysema __Lyme Disease
__Diabetes __Multiple Sclerosis
__Heart Disease __Pacemaker
__Seizures __Polio
__Tuberculosis __Varicose Veins

Other: _____
_____

Surgeries: _____
_____

Food intolerances or allergies? _____

How many glasses do you drink of the following per day?
Water _____
Soda _____
Coffee _____
Tea _____
Alcohol _____

Gastrointestinal:
Do you have currently or have you had a **major incidence** of the following in the past?
(Check all that apply)
__Hernia __Ulcers __Vomiting
__Indigestion __Nausea __Hemorrhoids
__Acid Reflux __Bloating __Nausea

Exercise and Energy:
Do you have a regular **exercise routine**? Y / N
What **forms of exercise** do you enjoy? _____
How often? _____
How is your **energy level**? _____

Emotions and Sleep:
How much do you sleep each night?
_____ (hours) from _____ AM/PM to _____ AM/PM

__Trouble falling asleep ___Trouble staying asleep
__Don't wake rested ___Intense/Disturbing dreams.
__Panic Attacks __Depression
__Nervous __Fearful

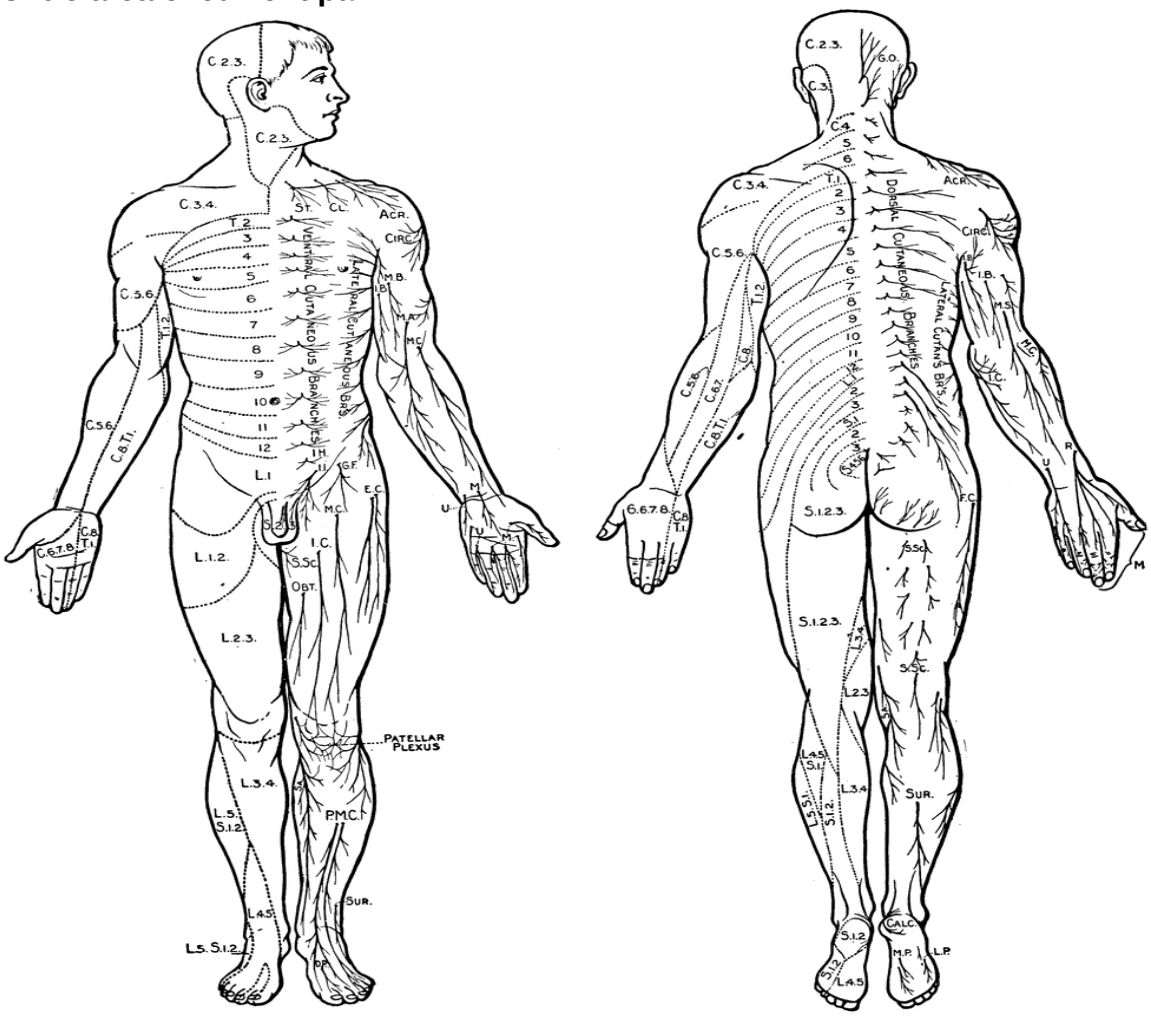
Gynecology:
__Pregnant
__Heavy flow __Light flow
__Blood Clots __PMS
__Uterine Fibroids __Cystic breasts

Respiratory:
Do you smoke? Y / N
_____times / day for _____ years
__Frequent colds __Asthma
__Bleeding gums __Dry mouth
__Ringing in ears __Sinusitis

Cardiovascular:
__Palpitations __Varicose Veins
__Poor circulation __Dizziness
__Irregular heart beat __High blood pressure
__Blood clots __Bruise easily

Musculoskeletal:
__Joint pain __Muscle tension
__Numbness __Tendonitis
__Osteoporosis __ Arthritis
__Swelling

Circle area of **current pain:**



Do you have any **additional health conditions** or **concerns**?

_____
_____
_____
_____

Signature _____ Date _____

If Minor, Parent/Guardian signature

_____