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

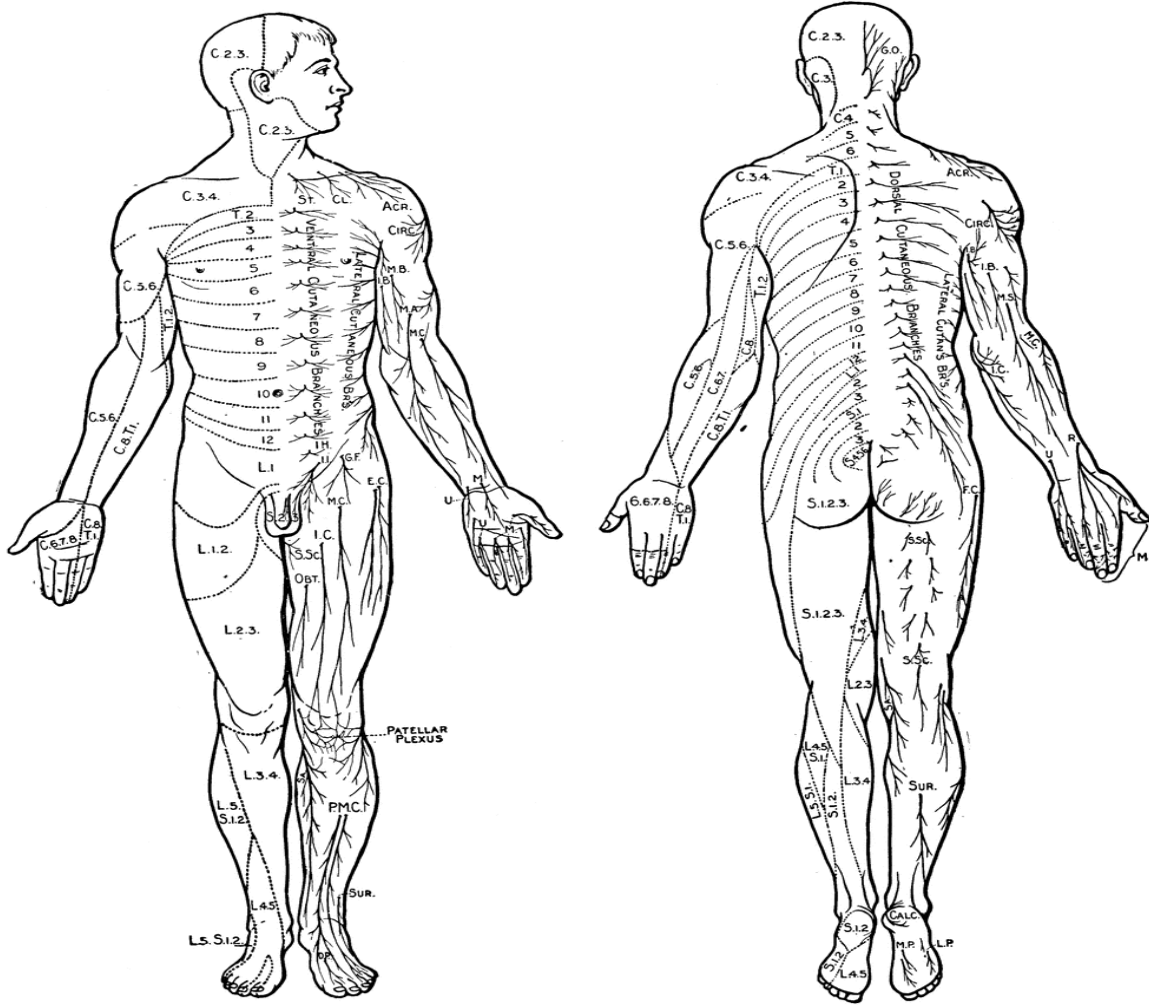**Musculoskeletal:**
__Joint pain   __Muscle tension
__Numbness   __Tendonitis
__Osteoporosis   __ Arthritis
__Swelling

Circle area of **current pain:**

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

_____
_____
_____
_____

Signature _____ Date _____

If Minor, Parent/Guardian signature

_____