|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Acupuncture Intake** | | | | | | | |
| Please complete this questionnaire carefully. The information you provide will assist in creating a complete health profile for you. All of your answers are strictly confidential. If you have any questions, please ask. | | | | | | | |
| **Name** *(Last, First):* | | Gender: | | | | | **DOB:**  **Age:** |
| **Relationship status:** | Single  Common Law  Married  Separated  Divorced  Widowed  Other | | | | | | |
| **Full Address:** | | | | | **Phone:**  **Cell:** | | |
| **Email Address:** | | | | | | | |
| **Extended Medical Insurer:** | | | | | **Occupation:** | | |
| **Family/Referring Doctor:** | | | | | **Doctor’s Phone:** | | |
| **Emergency Contact:**  **Relationship to You:** | | | | | **Emergency Contact Phone:** | | |
| **How did you hear about us?**  **Have you had Acupuncture before?** | | | | | | | |
|  | | | | | | | |
| **PERSONAL HEALTH HISTORY** | | | | | | | |
|  | | | | | | | |
| **Medical History:** | | | Asthma | High / Low Blood  Pressure | | Kidney Disease | |
| Arthritis | Pacemaker | | Liver / Gall Bladder Disease | |
| Broken Bones | Heart Disease | | Seizures | |
| Cancer | Bleeding Disorder | | Stroke | |
| Colitis / IBS / Crohn’s | Hepatitis \_\_\_\_ | | Substance Abuse | |
| Diabetes | Herpes / Shingles | | Thyroid Imbalance | |
| Gastritis | High Cholesterol | | Trauma / Abuse Survivor | |
| Gout | HIV / AIDS | | Tuberculosis | |
| **CHIEF COMPLAINTS** | | | | | | | |
| Please indicate your chief concerns for your health:   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Have you been given a specific diagnosis by a health professional for any of the above concerns? | | | | | | | |
|  | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MENTAL HEALTH** | | | | |
|  | | | | |
| Is stress a major problem for you? |  | Yes |  | No |
| Please rate your stress level on a scale of 0 to 10 (0 = no stress; 10 = extreme stress) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Do you feel depressed or anxious? |  | Yes |  | No |
| Do you suffer panic attacks or heart palpitations when stressed? |  | Yes |  | No |
| **sleep** | | | | |
| How many hours of sleep do you get a night on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Do you have trouble falling asleep? |  | Yes |  | No |
| Do you have trouble staying asleep? |  | Yes |  | No |
| Do you feel tired during the day? |  | Yes |  | No |
| Do you suffer from nightmares or frequent dreaming while asleep? |  | Yes |  | No |
| **Areas of concern** | | | | |
| Please mark the painful areas on the diagrams below and rate the discomfort on a scale of 0 to 10. | | | | |
| Do changes in the weather make your problem area better or worse?  Does applying heat or cold make your problem area better or worse?  Is there anything else that helps alleviate your symptoms?  C:\Users\Sam\Documents\Business Management\Business Intake Forms\Scanned Forms\BH097.jpg  Other Comments/Concerns: | | | | |