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| **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?** |
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| **PERSONAL HEALTH HISTORY** |
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| **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? |
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| **MENTAL HEALTH** |
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| 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.jpgOther Comments/Concerns: |