ACUPUNCTURE INTAKE FORM

Medical History

1. Please describe your main reason for seeking acupuncture treatment.

______________________________________________________________________________

2. Please describe any active medical problems (e.g., diabetes, asthma, and hypertension):

______________________________________________________________________________

3. Please describe any major accidents or injuries:

______________________________________________________________________________

4. Please describe any major surgeries or hospitalizations (e.g., appendectomy, cesarean section, gall bladder removal, hysterectomy)

______________________________________________________________________________

5. As you feel comfortable, please describe any traumatic situations you may have experienced (e.g., abuse, loss of a loved one, divorce)

-  

______________________________________________________________________________
Social History

1. Are you:
   ☐ Never Married       ☐ Married       ☐ Partnered/significant other
   ☐ Widowed            ☐ Divorced      ☐ Separated

2. Who lives at home with you? Include any pets.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. If you are working, please describe your current job.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Lifestyle

1. Please describe any allergies to medications, foods and/or environment:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Do you use tobacco products or e-cigarettes?
   ☐ No
   ☐ Yes; how much? _______ How many years? ___________.

3. Have you ever used tobacco products?
   ☐ No
   ☐ Yes; how much? ___________ How many years? _________ When did you quit? ______

4. Describe your typical
   Breakfast__________________________________________________________
   Lunch___________________________________________________________
   Dinner__________________________________________________________
   Snacks__________________________________________________________

5. How much alcohol do you consume? _________ Drinks per week
   What type? ☐ Beer       ☐ Wine       ☐ Liquor/mixed drinks

6. How much caffeine do you consume? _________ Drinks per week
   What type? ☐ Tea       ☐ Soda       ☐ Coffee/espresso drinks
7. How much soda pop do you consume? ________ Drinks per week
   What type? ☐ Regular ☐ Sugar-free (diet)

8. How much water do you consume? _______ glasses per day

9. Describe your activity level. Include information about your exercise routine, if you have one.
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Women’s Health

1. Date of last menstrual period: ________ Age menses began: _____

2. How many days between periods? __________

3. How many days of flow? ______ How heavy is your flow? ______


5. Please describe any problems you are having with your periods or menopause.
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

6. Please describe what type of contraception you are currently using, if any, and types you have used in the past.
   __________________________________________________________
# Symptoms Questionnaire

Please check all symptoms that you are currently experiencing. Add any details that you wish on the sides of the page.

<table>
<thead>
<tr>
<th>Head</th>
<th>Nose</th>
<th>Eyes</th>
<th>Skin</th>
<th>Oral</th>
<th>Heart</th>
<th>Ears</th>
<th>Lungs</th>
<th>Mind</th>
<th>Endocrine</th>
<th>Emotions</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Headaches</td>
<td>☐ Stuffy nose</td>
<td>☐ Watery or itchy eyes</td>
<td>☐ Acne</td>
<td>☐ Frequent need to clear throat</td>
<td>☐ Irregular or skipped heartbeats</td>
<td>☐ Itchy ears</td>
<td>☐ Chest congestion</td>
<td>☐ Poor memory</td>
<td>☐ Cold intolerance</td>
<td>☐ Mood swings</td>
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<tr>
<td>☐ Faintness</td>
<td>☐ Sinus problems</td>
<td>☐ Swollen, reddened eyelids</td>
<td>☐ Hives/rashes</td>
<td>☐ Sore throat, hoarseness</td>
<td>☐ Rapid or pounding heartbeat</td>
<td>☐ Earaches, ear infections</td>
<td>☐ Asthma, bronchitis</td>
<td>☐ Poor concentration</td>
<td>☐ Increased thirst</td>
<td>☐ Anxiety, fear, nervousness</td>
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<tr>
<td>☐ Dizziness</td>
<td>☐ Hay fever</td>
<td>☐ Bags or dark circles under eyes</td>
<td>☐ Dry skin</td>
<td>☐ Swollen tongue, gums or lips</td>
<td>☐ Chest pain</td>
<td>☐ Drainage from ear</td>
<td>☐ Shortness of breath</td>
<td>☐ Poor physical coordination</td>
<td>☐ Hyperactivity</td>
<td>☐ Panic attacks</td>
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<td></td>
<td>☐ Sneezing attacks</td>
<td>☐ Blurred or tunnel vision</td>
<td>☐ Hair loss</td>
<td>☐ Canker sores</td>
<td>☐ Difficulty breathing</td>
<td>☐ Ringing in ears</td>
<td>☐ Difficulty breathing</td>
<td>☐ Poor physical coordination</td>
<td>☐ Restlessness</td>
<td>☐ Anger, irritability</td>
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<td>☐ Excessive mucus formation</td>
<td>☐ Headaches</td>
<td>☐ Hay fever</td>
<td>☐ Loss of taste</td>
<td>☐ Wheezing</td>
<td>☐ Hearing loss</td>
<td>☐ Difficulty making decisions</td>
<td>☐ Difficulty falling asleep</td>
<td>☐ Increased thirst</td>
<td>☐ Depression</td>
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<tr>
<td></td>
<td>☐ Nosebleeds</td>
<td>☐ Sinus problems</td>
<td>☐ Hay fever</td>
<td>☐ Loss of smell</td>
<td>☐ Cough</td>
<td>☐ Night flash</td>
<td>☐ Seasonal Mood disorder</td>
<td>☐ Difficulty staying asleep</td>
<td>☐ Hot flashes</td>
<td>☐ Worry/rumination</td>
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<td></td>
<td>☐ Loss of smell</td>
<td>☐ Hay fever</td>
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<td></td>
<td>☐ Night sweats</td>
<td>☐ Post-traumatic stress</td>
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<td></td>
<td>☐ Decreased sexual desire</td>
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Pain Center
Ph: (651) 232-5354
Fax: (651) 232-5217

NAME: _______________________
DATE OF BIRTH: _______________

☐ Hopeless/worthless feeling

Urinary
☐ Frequent urination
☐ Painful urination
☐ Decreased Flow
☐ Urgency
☐ Unable to hold urine

Musculo-skeletal
☐ Pain or aches in the joints
☐ Stiffness or limitation of movement
☐ Pain or aches in muscles
☐ Muscle weakness or tiredness

GI Tract
☐ Bad breath (despite good dental hygiene)
☐ Reflux/Heartburn
☐ Difficulty swallowing
☐ Poor appetite
☐ Food intolerance
☐ Getting full easily
☐ Excessive hunger
☐ Nausea
☐ Vomiting
☐ Abdominal bloating
☐ Abdominal pain or cramping
☐ Diarrhea
☐ Constipation
☐ Significant burping, belching, hiccupping
☐ Intestinal gas

Menstrual
☐ Heavy flow
☐ Clotting
☐ Painful cramping
☐ Menopausal
☐ Vaginal burning, itching, dryness
☐ Pain with intercourse
☐ PMS

Weight
☐ Binge eating or drinking
☐ Craving certain foods
☐ Weight gain/loss
☐ Compulsive eating
☐ Water retention

Bowel movement
Frequency_______Color_____________
☐ Well-formed
☐ Undigested food
☐ Floats
☐ Loose
☐ Hard or painful
☐ Sinks
☐ Blood
☐ Mucus
Male System ☐ Prostate problems
☐ Change in sexual drive
☐ Rashes/itching
☐ Genital discharge
☐ Erection difficulty
☐ Low sperm count/motility
☐ Impotence
☐ Hernia
☐ Genital Pain or Sores
☐ Nocturnal Emissions
☐ Gout

Please return entire packet to:
HealthEast Pain Center
1600 St. John’s Blvd. Ste. 101
Maplewood MN 55119