HealthEast Care System

Pain Center
Ph: (651) 232-5354
Fax: (651) 232-5217

NAME:______________________________

DATE OF BIRTH::____________________

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

HealthEast Care System

Pain Center
Ph: (651) 232-5354
Fax: (651) 232-5217

NAME:______________________________

DATE OF BIRTH::___________________

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?______

4. How many pregnancies?____ Miscarriages :____ Abortions:____ Births: ____ Living Children:____

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.

Head
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness

Eyes
- ☐ Watery or itchy eyes
- ☐ Swollen, reddened eyelids
- ☐ Bags or dark circles under eyes
- ☐ Blurred or tunnel vision

Oral
- ☐ Frequent need to clear throat
- ☐ Sore throat, hoarseness
- ☐ Swollen tongue, gums or lips
- ☐ Canker sores
- ☐ Loss of taste

Ears
- ☐ Itchy ears
- ☐ Earaches, ear infections
- ☐ Drainage from ear
- ☐ Ringing in ears
- ☐ Hearing loss

Energy
- ☐ Fatigue, sluggishness
- ☐ Apathy, lethargy
- ☐ Hyperactivity
- ☐ Restlessness
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine
- ☐ Cold intolerance
- ☐ Increased thirst
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Decreased sexual desire

Nose
- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Hay fever
- ☐ Sneezing attacks
- ☐ Excessive mucus formation
- ☐ Nosebleeds
- ☐ Loss of smell

Skin
- ☐ Acne
- ☐ Hives/rashes
- ☐ Dry skin
- ☐ Hair loss
- ☐ Excessive sweat
- ☐ Change in nails
- ☐ Itching
- ☐ Bruise easily

Heart
- ☐ Irregular or skipped heartbeats
- ☐ Rapid or pounding heartbeat
- ☐ Chest pain

Lungs
- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Cough

Mind
- ☐ Poor memory
- ☐ Poor concentration
- ☐ Poor physical coordination
- ☐ Difficulty making decisions
- ☐ Learning disabilities

Emotions
- ☐ Mood swings
- ☐ Anxiety, fear, nervousness
- ☐ Panic attacks
- ☐ Anger, irritability
- ☐ Depression
- ☐ Worry/rumination
- ☐ Seasonal Mood disorder
- ☐ Post-traumatic stress
- ☐ Compulsive

HealthEast Care System

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