LAKE WASHINGTON ACUPUNCTURE INTAKE FORM

This information is confidential Date:____________________

Name: ______________________________ Age: ________ Birthdate: ________________

Address: ____ Sex: M / F

City: _________________________ State: _____________ Zip Code: ________________

Phone number: ____ e-mail ___________________

Occupation: ____

Physician: ____ Physician Phone #: ________

Have you ever had acupuncture? Y / N (circle one)

What is your current concern? ____

How long? ____

What other treatments have you tried? ____

Medications you are currently taking:	For what conditions:
_________________________________	___________________________________
_________________________________	___________________________________
_________________________________	___________________________________
_________________________________	___________________________________

Surgeries: ____

Medical History (check all that apply):

- □ Aids/HIV
- □ Alcohlism/Substance Abuse
- □ Allergies to Latex
- □ Cancer
- □ Diabetes
- □ Emphysema
- □ Heart Disease
- □ Hepatitis A / B / C
- □ Herpes
- □ Lyme Disease
- □ Multiple Sclerosis
- □ Pacemaker
- □ Polio
- □ Seizures
- □ Tuberculosis
- □ Varicose Veins
- □ Other: ___________________

Food Intolerances or allergies?

How many glasses do you drink each day of the following per day?

Water ________ Soda ______ Coffee __________ Tea _______ Alcohol __________

Gastrointestinal:

Do you have currently or have you had a major incidence in the past?

_______ Belching _______Indigestion _______Ulcers

_______Hernia _______Nausea _______ Vomiting

_______Bloating _______ Acid Reflux _______ Hemorrhoids

Exercise and Energy:

What kind of exercise do you do? ____________________________ How often? ______________

How is your general energy level? ____

Are you sedentary or active?____

Emotions and Sleep:

_______ Panic Attacks _______ Depression _______ Anxiety _______ Difficulty Concentrating

_______Nervous _______ Fearful _______ Poor Memory

Gynecology:

Are you still menstruating? _____________________

_______ Heavy flow _______ Light flow _______ No flow

_______Blood clots _______ PMS _______ Painful periods

_______Uterine fibroids _______ Cystic breasts

Respiratory:

Do you smoke? Y / N _______ times /day for _______ years

_______ Frequent Colds _______ Asthma _______ Cough _______ Cold Sores

_______ Bleeding Gums _______ Dry mouth _______ Ear pain _______ Migraine

_______ Ringing in Ears _______ Sinusitis _______ Excessive Phlegm

Cardiovascular:

_______ Palpitations _______ Varicose Veins _______ Cold hands/feet

_______ Poor circulation _______ Dizziness _______ Chest pain

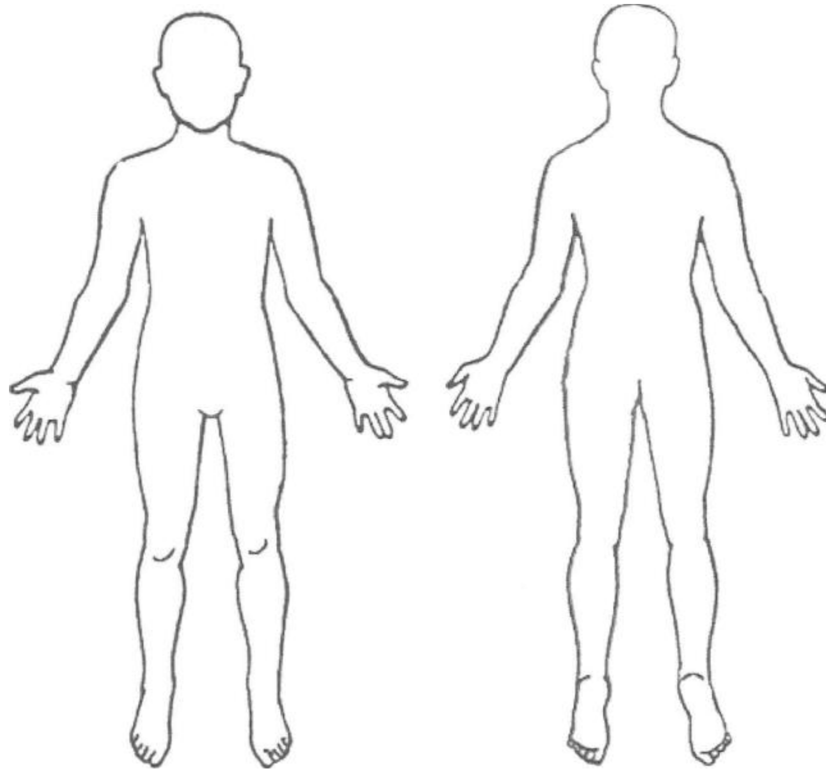
_______ Irregular heart beat _______ High blood pressure _______ Low blood pressure

_______ Blood clots

Musculoskeletal : Numbness

_______ Joint pain _______ Arthritis _______ Muscle tightness
_______ Tendonitis _______ Osteoporosis _______ Swelling

Mark with an (X) where you are feeling any discomfort or pain.



If pain, please describe: Sharp Dull Stabbing (please circle)

Do you have any additional health conditions or concerns?

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____

____

Print Name ____

Patient Signature ____ Date:________