Acupuncture Tree of Life

CONFIDENTIAL INTAKE FORM

Today's Date_____

Name_____

Address_____

Phone Numbers_____

E-mail_____

Birth Date_____

Primary Care Practitioner's Name and Phone_____

_____

What do you want treated with acupuncture?_____

_____

What do you consider your main complaint?_____

_____

How long have you had it?_____

What Gives relief?_____

What makes it worse?_____

What medical diagnosis have you been given?_____

What medical treatment have you had?_____

Secondary complaint(s)_____

What would you like to achieve from treatment with acupuncture?_____

PAST MEDICAL HISTORY

Have you had any of these? Please circle all that apply.

Alcohol/Drug Dependency	Allergy	Anaphylaxis	Asthma
Autoimmune Disease	Bleeding Disorder	Cancer	Diabetes
Gatrointestinal Disorder	Hearth Disease	High Blood Pressure	Hepatitis
HIV	Kidney Disease	Lung Disease	Neurological Disease
Seizure	Surgery	Thyroid Disorder	Trauma

Other Serious Illness_____

Current Medications_____

_____

FAMILY MEDICAL HISTORY

Please list any of the above that apply.

Mother_____

Father_____

Sibling(s)_____

TEMPERATURE/SWEATING/THIRST Please Circle all that apply

Tendency to feel cold Tendency to feel hot Tendency to sweat Tendency to feel thirsty

Which season(s) do you prefer? Spring Summer Fall Winter

APPETITE/DIET Please please circle all that apply.

No real appetite Food Cravings Food Allergies

How many meals per day do you eat?_____Did you eat yet today?_____

Do you regularly ingest these?_____

Meat Sweets Vitamins Vegetables Coffee Supplements Dairy

Which taste(s) do you prefer? Salty Sweet Spicy Sour Bitter

DIGESTION/ELIMINATION Please circle all that apply.

Reflux	Vomiting	Belching	Nausea	Bloating	Indigestion
Gas	Pain	Cramps	Burning	Blood in Stool	Hemorrhoids
Diarrhea	Constipation	Loose Stool	Incontinence	Urinary Frequency	Blood in Urine

ENERGY/ EXERCISE / SLEEP Please circle all that apply.

Generally energy is good Tendency to tire easily or at certain time of day Feel tired all the time

What type of exercise do you do?_____

How often do you exercise?_____

How many hours do you sleep per night?_____

Use a sleeping pill Difficulty falling asleep Disturbed sleep

EMOTIONS/ MIND

What is your work and how do you feel about it?_____

What is your primary relationship and how do you feel about it?_____

When you are stressed, where do you feel it?_____

How do you relax?_____

How many vacation weeks do you take per year?_____

Please circle all that apply.

Anger	Irritability	Lack of Joy	Anxiety	Depression	Sadness
Fear	Difficulty Concentrating	Poor Memory	Use anti-anxiety medication	Use anti-depressant medication	

SKIN/HAIR Please circle all that apply

Rash Eczema Psoriasis Acne Itching Dryness Hair Loss Scars

HEAD/EYES/EARS/NOSE/THROAT/BREATHING Please circle all that apply.

Headaches	Poor Vision	Poor Hearing	Ringing in Ears	Nasal Congestion	Runny Nose
Sinusitis	Nose Bleeds	Sore Throat	Cough	Phlegm	Shortness of Breath
Asthma	Hay Fever/Allergies	Frequent Colds			

CIRCULATION Please circle all that apply.

Dizziness Fainting Irregular Heartbeat Palpitations Swelling

MUSCLES/BONES/JOINTS Please circle all that apply.

Traumatic Injury Osteoarthritis Rheumatoid Arthritis Tendonitis
Repetitive Strain Injury Muscle Pain/Weakness Joint Pain

Where do you have pain or tightness?_____

Describe your pain by circling all that apply.

Sharp Dull Aching Burning Numb/Tingling
Better with Heat Better with Cold Better with Massage Better with Exercise

SEX/REPRODUCTION

Men – Please circle all that apply

Erectile Dysfunction Low Libido

Women—Please circle all that apply.

Irregular Periods No Periods Spotting Between Periods Painful Periods Heavy Periods
Vaginal Discharge Premenstrual Symptoms Menopausal Symptoms Low Libido

How many days in your menstrual cycle?_____ How many days does your period last?_____

Are you presently trying to get pregnant?_____ What form of birth control do you use, if any?_____

Have you ever been pregnant?_____Number of full term pregnancies?_____