



GoodMedizen Acupuncture & Herbs

Acupuncture Intake Form

This information is confidential

Date: _____

Name: _____ Age: _____

Address: _____ Sex: M / F

City: _____ State: _____ Zip Code: _____

Phone number: _____

Birth Date: _____ e-mail _____

Occupation: _____

Physician: _____ Physician Phone #: _____

Have you ever had acupuncture? Y / N

What is your current concern? _____

_____ How long? _____

What other treatments have you tried? _____

Medications you are currently taking: For what conditions:

Medical History (Check all that apply)

Aids/HIV Alcoholism/Substance Abuse

Allergies to Latex Hepatitis A / B / C

Cancer Herpes

Emphysema Lyme Disease

Diabetes Multiple Sclerosis

Heart Disease Pacemaker

Seizures Polio

Tuberculosis Varicose Veins

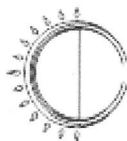
Other _____

Surgeries: _____

Food Intolerances or allergies? _____

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

Water _____ Soda _____ Coffee _____ Tea _____ Alcohol _____



GoodMedizen Acupuncture & Herbs

Gastrointestinal:

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

- | | | |
|-----------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Belching | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> 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:

- | | | | |
|--|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Difficulty Concentrating |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Fearful | <input type="checkbox"/> Poor Memory | |

Gynecology:

Are you still menstruating? _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Heavy flow | <input type="checkbox"/> Light flow | <input type="checkbox"/> No flow |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> PMS | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Cystic breasts | |

Respiratory:

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

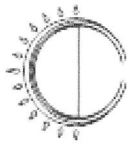
- | | | | |
|--|------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Excessive Phlegm | |

Cardiovascular:

- | | | |
|---|--|---|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Blood clots | | |

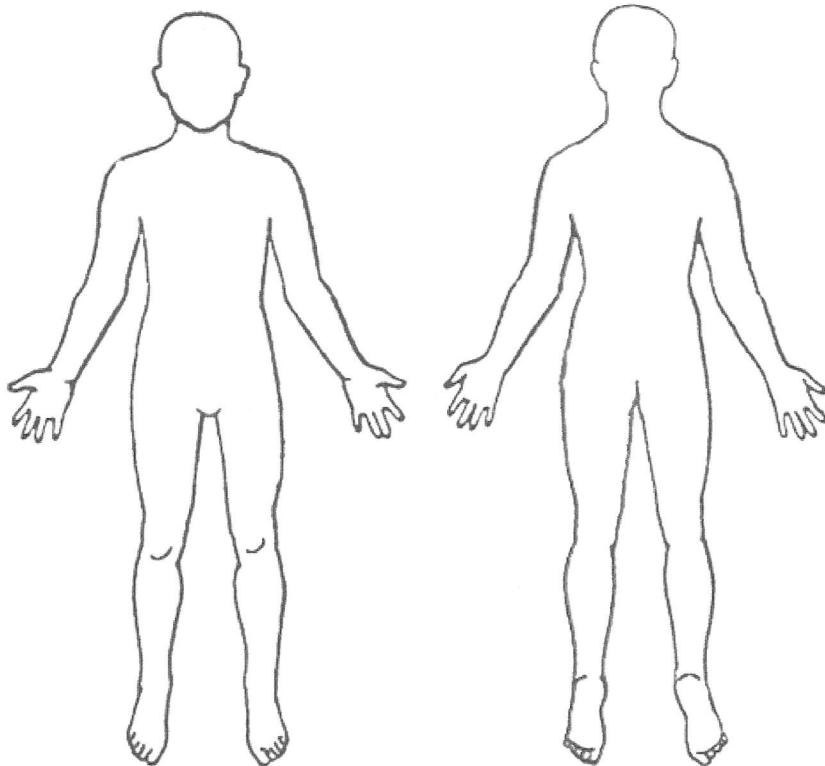
Musculoskeletal:

- | | | | |
|-------------------------------------|---------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle tightness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Swelling | |



GoodMedizen Acupuncture & Herbs

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



If pain, please describe:

Sharp

Dull

Stabbing (please circle)



GoodMedizen Acupuncture & Herbs

Do you have any additional health conditions or concerns? _____

Print Name _____

Patient Signature **X** _____