HEALING WITHIN
Acupuncture & Wellness Studio

Acupuncture Intake Form
Aimee Van Ostrand, L.Ac.

Thank you for taking the time to fill out this intake form honestly and completely.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name_____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone _____ Mobile _____

e-mail address_____

How did you hear about us? _____

In case of emergency contact _____

Phone _____ Relationship _____

Please describe the reason for your visit today (Chief Complaint) _____

_____

Is it getting better, worse, or staying the same? _____

_____

Are you, or have you been, treated for this problem with any other health professionals?

_____

Has it been effective? _____

What was your diagnosis? _____

Please list any medication, vitamin or herbal supplements that you are taking, include dosage if known. Use the back of this page if necessary.

MEDICAL HISTORY

Please circle any current health issue. For those diseases which are part of your health history, please note the year of the occurrence.

Allergies
Anemia
Appendicitis
Arteriosclerosis
Asthma
Bleeding Disorder
Blood Pressure (Low or High)
Cancer
Chicken Pox
Diabetes
Digestive Disorders
Emotional Difficulties
Emphysema
Epilepsy
Fatigue
Gout
Heart Disease
Hepatitis (A, B,C)
Hypoglycemia
Injuries
Insomnia
Intestinal Parasites
Multiple Sclerosis
Mumps
Pacemaker
Weight Loss or Gain
Polio
Scarlet Fever
Stroke
Recent surgery (List):
_____
_____
_____
Thyroid Disorder
Trauma (falls, accidents)
Tuberculosis
Ulcers
Other_____
_____

Do any of your family members suffer from: (Please list relationship to you)

Alcoholism
Allergies (list)
_____
_____
Arteriosclerosis
Asthma
Cancer
Diabetes
Heart Disease
High Blood Pressure
Seizures
Stroke

Do you have a reaction to latex, silicone, nickel or essential oils? If yes, please describe:

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Which of the following is part of your lifestyle? How frequently do you engage in it?

Alcohol	Tobacco or nicotine	Exercise
Coffee /caffeine	Recreational drug use	Meditation, yoga, prayer
Excessive sugar	Obsessive behavior	Safe sex

Do you usually eat three meals a day? _____Do you follow any particular diet? if yes,

Please describe: _____

On the scale of 1-10, how would you rate the level of stress in your life currently? _____

What is the level of stress in your life in general (1-10)? _____

How does stress affect you? (ie, more headaches, stomach pain, etc.) _____

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REVIEW OF SYSTEMS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! Place **one check** next to a symptom you have experienced, **two checks** next to a frequently occurring symptom, and **three checks** next to a symptom that is particularly distressing to you.

Head and Face
Headaches
Dizziness
Memory Loss
Other

Eyes
Blurry Vision
Eyelid Twitching
Floaters
Pain

Nose
Frequent Colds
Sinus Trouble
Bleeding

Mouth
Dental Problems
Gum Problems
Teeth Grinding/TMJ
Unusual Tastes
Other

Throat
Sore Throat
Hoarseness
Difficulty Swallowing
Dryness
Other

Respiration
Difficulty Inhaling
Difficulty Exhaling
Pain
Cough
Congestion
Shortness of Breath
Other

Heart and Chest
High Blood Pressure
Low Blood Pressure
Chest Pain
Chest Tightness
Difficulty Lying Down
Other

Circulation
Easy Bruising
Easy Bleeding
Cold Limbs-Hands or Feet
Reynaud's Syndrome

Gastrointestinal
Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain
Nausea
Diarrhea/Loose Stools
Constipation
Rectal Bleeding
Colon Problems

Urination
Frequent
Difficult
Painful
Nocturnal
Bleeding
Other

Skin
Acne
Dryness
Moles that Change
Lumps
Excessive Sweating
Night Sweats
Rarely Sweat
Other

Neurological
Nervousness/Anxiety
Tremors
Numbness or Tingling
Lack of Coordination
Nerve Pain
Other

Sleep
Insomnia
Drowsiness
Excessive Dreaming
Waking Easily
Other

Pain - Please Describe
_____
_____
_____
_____

Are there any other health concerns you'd like to address?
_____
_____

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WOMEN ONLY

Are you, or could you be pregnant?_____ If so, how far along?_____

Number of pregnancies_____ Births_____ Abortions_____ Miscarriages_____

What form of birth control do you use?_____

Do you have regular PAP smears?_____ How Often? _____

Age of first menses_____ Age of menopause, if applicable_____

Do you bleed between periods?_____ Do you bleed after intercourse?_____

Have you ever had any gynecological surgeries or any abnormal findings on any tests?__

_____

Are your periods uncomfortable or painful, either emotionally or physically?_____

_____

Are your periods:

Short (Less than 28 days)_____Long (28+ days)_____Varied_____ Regular_____

Painful? If so, Before_____ During_____ After_____

Do you bleed heavily_____? Lightly_____? Very little?_____

Do you have clots ?_____ Early in the cycle_____ or throughout?_____

Relative to the blood that comes from a wound, is your menstrual blood: The same color_____ More pale_____ Purple_____ More Red_____ More Brown_____

How many days do you bleed?_____

Do you have any of the following Pre-Menstrual Symptoms?

Irritability____ Depression_____ Crying_____ Rage_____ Nausea_____

Breast Tenderness_____ Cravings, and if so for what?_____

Any other symptoms around the time of your period?_____

_____

Are you experiencing any low or high sexual desires?_____ Do you have any concerns surrounding this? _____

Do you have any other gynecological concerns or complaints?_____

MEN ONLY

Do you experience any of the following:

Reduced Libido_____ Excessive Libido_____ Impotence_____

Urinary Frequency_____ Premature Ejaculation_____ Discharge_____

Genital/ Testicular pain_____

Any other concerns?_____

I have provided correct and complete information to the best of my knowledge.

_____ _____

Patient's or Guardian's signature Date