ACUPUNCTURE
BODYWORK

108 West 39th Street, Suite 1205
New York, NY 10018
Phone: 212.967.3079
Email: maureen@acupuncturebodywork.com
Website: www.acupuncturebodywork.com

Patient Intake Form

Note: Information provided on this form is confidential. **Today's Date**_____
It is very important the information given is complete and accurate to assist you properly in your healing process

PERSONAL INFORMATION - PLEASE PRINT

How did you hear about us?_____

Name _____Date of Birth_____

Age_____ Gender_____ Marital Status_____

Occupation_____

Address_____

City/State/Zip_____

Phone # (W) _____ (H) _____ (Cell) _____

Email Address_____

Mailing Address_____

Name, phone number, and relationship of an emergency contact person:

_____

Primary physician's name, phone #, and address_____

_____

What do want treated with acupuncture ? _____

How long have you had this condition ? _____The onset was sudden ☐ gradual ☐

Symptoms relieved by: _____Symptoms worsened by: _____

Are you taking any medications? _____

For what condition(s) _____

Is this your first experience in Oriental Medicine and acupuncture? _____

Are you currently pregnant? Yes ☐ No ☐

Are you currently trying to get pregnant? Yes ☐ No ☐

How do you feel about acupuncture? _____

PAST MEDICAL HISTORY

Have you had or have any of these conditions (Please check all that apply)

☐ AIDS/HIV	☐ Alcoholism	☐ Allergies (food, latex)
☐ Asthma	☐ Birth Trauma	☐ Cancer
☐ Diabetes	☐ Drug Addictions	☐ Emphysema
☐ Fibromyalgia	☐ Heart Disease	☐ Hepatitis A/B/C
☐ Herpes	☐ Joint Replacements	☐ Lyme's Disease
☐ Lymph Nodes removed	☐ Multiple Sclerosis	☐ Pacemaker
☐ Polio	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Frequent use of antibiotics	☐ Seasonal Allergies	☐ Seizures
☐ Illnesses, accidents or injuries	☐ Sinus Infections	☐ Other
☐ Tuberculosis	☐ Operations	☐ Vaccinations

FAMILY MEDICAL HISTORY

(Please list any signifi cant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother: _____

Father: _____

Siblings: _____

Grandparents:_____

Exercise and Energy:

How is you energy? _____

What time of day is your energy: Highest? _____Lowest?_____

Do you fatigue easy? _____

What kind of exercise do you do? _____

How often do you exercise? _____

Emotions and Sleep:

How do you feel emotionally? _____

I have or often have (Please check all that apply)

☐ Panic Attacks	☐ Depression	☐ Anxiety
☐ Nervousness	☐ Bad Temper	☐ Fear Attacks
☐ Poor Memory	☐ Difficult-concentration	☐ Insomnia

Are you in a relationship? Yes ☐ No ☐

How do you feel about your relationship? _____

How do you hold stress? _____

How do you relax? _____

Eyes, Ears, Nose & Throat:

Do you smoke? Yes ☐ No ☐ _____ per day, for year(s)_____

I have or often have (Please check all that apply)

☐Frequent colds	☐Chronic runny nose	☐Frequent sore throat
☐Chronic Cough	☐Coughing blood	☐Cough up mucous
☐Pain inhaling	☐Shortness of breath on exertion/at rest	☐Asthma
☐Nose bleeds	☐Painful/red eyes	☐Poor vision
☐See spots/floaters	☐Dizziness	☐Cold sores
☐Bleeding gums	☐Dry mouth	☐Ear Pain
☐Ringing in ears	☐Clogged/popping in ears	☐Other

Describe: _____

☐Frequent headaches/migraines Describe: _____

_____

Cardiovascular:

I have (Please check all that apply)

☐Chest pain	☐Palpitation	☐Varicose veins
☐Phlebitis	☐Cold hands and feet	☐Irregular heart beat
☐Poor circulation	☐ Other Describe: _____	

_____

Skin & Hair:

I have or often have (Please check all that apply)

☐Dry Skin	☐Skin Rashes	☐Itching
☐Acne	☐Eczema	☐Hives
☐Hair Loss	☐Pre-mature graying	☐Other

Describe: _____

_____

Muscles, Joints & Bones:

Do you have pain or tightness? Yes ☐ No ☐ Where? _____

The pain is (Please check all that apply)

☐Sharp	☐Dull	☐Aching
☐Pain worse/better with cold	☐Superficial pain	☐Deep pain
☐Pain worse/better with pressure	☐Tingling	☐Shooting
☐Pain worse/better with heat	☐Numb	☐Burning
☐Pain worse in am/pm	☐Other	

Describe:_____

_____

I have (Please check all that apply)

☐Swollen joints	☐Arthritis/joint pain	☐Tendonitis
☐Bone pain	☐Muscle cramping	☐Muscle pain
☐Repetitive Strain Injury	☐Fractured Bone(s)	

Where? _____

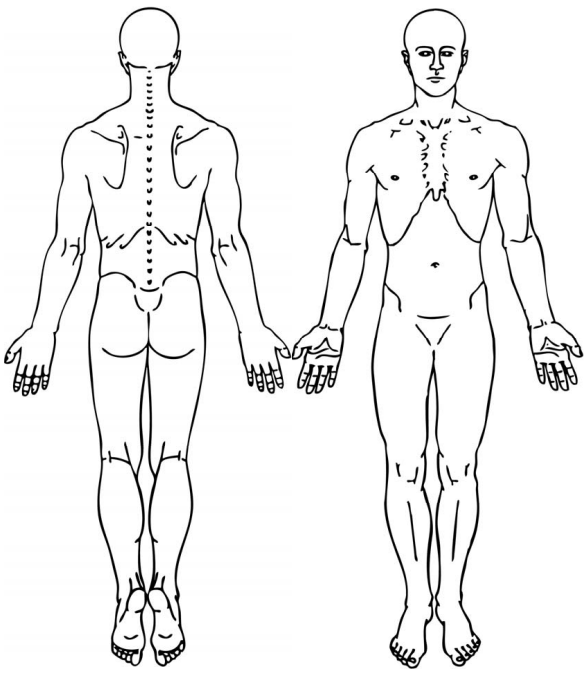
RATE YOUR AVERAGE DISCOMFORT ON THE SCALE:

0_____10

(no pain) (severe pain)

PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATION ON THE BODY MAP BELOW:

XXX = Pain **000 = Numb/Tingle** *** * * = Weakness**



Print Reset Form