

4 Branches Community Acupuncture Intake Questionnaire

Date: _____

Name: _____

Phone: _____

Address: _____

Cell: _____

City, State, Zip _____

Work: _____

D.O.B. _____ Age _____

E-Mail: _____

Occupation: _____

Want to receive our newsletter? Y N

Employer _____

Emergency Contact Information:

Primary M.D. _____

Name: _____

M.D. Phone: _____

Relationship; _____

Have you ever had acupuncture before? Y N

Phone: _____

Are you, or may you be pregnant? Y N

How did you hear of us? _____

HEALTH HISTORY

Please state your **3 primary health concerns** below and rate the severity
Check **ALL** that apply (both CURRENT & PAST): of each on a scale
of 1-10 (1 = little, 10 = extreme). Δ =change

1. _____
Severity (1-10): _____ Time problem has persisted: _____
How does each of the following affect the problem?

	Better	Worse	No Δ
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dampness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. _____
Severity (1-10): _____ Length problem has persisted: _____
How does each of the following affect the problem?

	Better	Worse	No Δ
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dampness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. _____
Severity (1-10): _____ Length problem has persisted: _____
How does each of the following affect the problem?

	Better	Worse	No Δ
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dampness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List all surgeries, accidents, fractures, serious injuries & hospitalizations:

	You	Family History
AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>
Addictions	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / C.O.P.D.	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>
STD	<input type="checkbox"/>	<input type="checkbox"/>

HABITS

How often & in what amounts do you use the following:

Caffeine: _____

Nicotine: _____

Alcohol: _____

Drugs: _____

How often do you exercise: _____

Rate your average energy level (1 = low, 10 = high):

(circle one) 1 2 3 4 5 6 7 8 9 10

List any & all Medications, Birth Control, HRT, Herbs, or Supplements you are currently taking:

Name:	Reason:	Name:	Reason:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check ANY symptoms that you CURRENTLY HAVE or HAVE HAD IN THE PAST YEAR:

MUSCLE / JOINTS / TENDONS / BONES:

- Swollen joints
- Cramps or Spasms
- Tremors

TYPE OF PAIN _____
(burning, aching, sharp, stabbing, heavy, etc.)

PAIN, NUMBNESS, OR WEAKNESS in:

- | | | |
|--|--------------------------------|--|
| <input type="checkbox"/> Hands / Wrist | <input type="checkbox"/> Back | <input type="checkbox"/> Feet / Ankles |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Legs | <input type="checkbox"/> Jaw / TMJ |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Hips | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Knees | _____ |

EYES, EARS, NOSE, THROAT

- Blurred / Failing vision
- Red eyes
- Itchy/Dry eyes
- Spots in front of eyes
- Ringing in ears
- Earache
- Loss of hearing
- Sinus congestion
- Nosebleeds
- Hay fever / Allergies
- Frequent colds
- Sore throat
- Cough
- Phlegm Color _____
- Hoarseness
- Dry mouth/throat
- Mouth sores / Canker sores

TEMPERATURE

- Cold hands or feet
- Chills
- Hot flashes
- Fever or heat sensations
- Sweating
- Night / Day sweating

CARDIOVASCULAR (circle to specify)

- Angina / Chest pain
- Arteriosclerosis
- Heart Attack / MI
- High/Low blood pressure
- High cholesterol
- Irregular/Rapid heartbeat
- Palpitations
- Poor circulation
- Swollen ankles / Congestive Heart Failure

GENITO/URINARY

- Blood/Pus in Urine
- Frequent urination → Scant amount Profuse amount
- Incontinence or unable to control urine
- Kidney infection / Kidney stones
- Low libido
- Other: _____

EMOTIONAL SYMPTOMS

- Anger / Irritability
- Anxiety / Nervousness
- Depression
- Easily startled / Indecisive
- Excessive Fear
- Excessive Grief
- Excessive Worry
- Forgetfulness, difficulty in focusing
- Mania / Hypomania
- Suicidal thoughts

GENERAL (circle to specify)

- Insomnia / Poor sleep / Awaken early
- Headaches / Migraines
- Dizziness / Vertigo
- Fatigue / Tiredness
- Excessive Thirst

SKIN (circle to specify)

- Acne / Boils / Cysts
- Bruise easily
- Dry skin / Hair and/or Nail problems
- Itching / Rash / Hives
- Eczema

FOR MEN ONLY

- Erection difficulties / Impotence
- Hernia / Groin pain
- Penis discharge
- Premature ejaculation
- Prostate problems

FOR WOMEN ONLY

- Age of first menses: _____
- Days between menses: _____
- Number of pregnancies: _____
- Miscarriage(s)
- # of miscarriages (if applicable): _____
- Clots in menses
- Bleeding between periods
- Irregular cycles
- Menopausal symptoms
- PMS
- Light periods
- Heavy periods
- Painful periods
- Spotting / Scanty flow
- Yeast infections
- Other: _____

GASTROINTESTINAL (circle to specify)

- Belching / Bloating / Gas
- Colitis / Colon problems / IBS
- Constipation
- Diarrhea
- Bloody stools
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder problems
- Hemorrhoids
- Indigestion / GERD / Acid reflux
- Nausea
- Pain in stomach area
- Poor appetite
- Vomiting
- Other: _____

All information on this form is correct to the best of my knowledge.

Signature: _____

Date: _____