

Facial Acupuncture Intake Form
Blue Peacock Acupuncture
Erin Dietz, L.Ac, LMP
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206-547-1510

Information Confidential: Please fill out this form carefully.

Name Date

Age Sex (M/F) Birth Date Occupation

Address

City State Zip Phone

Email

Emergency contact Phone

How did you hear about me?

Primary Physician

When did you last go to a doctor's office, medical clinic, or hospital?
What was the reason?

Please list any major illnesses and injuries you have had and approximate date of onset:

Please list any hospitalizations or surgeries you have had:

What are your most important health concerns?

Please list any specific medications or herbal supplements that you are currently taking:

	Medical History (Please check all that apply)
	AIDS/HIV
	Allergies: To what?
	Asthma
	Emphysema
	Cancer
	Diabetes
	High blood Pressure
	Stoke
	Heart disease
	Pacemaker
	Herpes
	Hepatitis A/B/C
	Tuberculosis
	Depression
	Mental illness
	Other

Diet:

Please briefly describe your typical diet:

Breakfast

Lunch

Dinner

Snacks

Food cravings

Beverages (how many glasses/cups per day?):

Water Soda Coffee Tea Alcohol

Do you prefer:

 hot drinks cold drinks no preference

Are you always thirsty?

 Yes No

Servings consumed per day/week:

 Meat Sugar/Sweets Dairy/milk/cheese

Please indicate taste preference on 1-5 scale (1= strongly like; 3=like OK; 5= strongly dislike):

Salty Sour Bitter Sweet Spicy

Urination:

	Do you, or have you had
	Frequent urination
	Incontinence
	Burning urination
	Bladder infections

GYN:

Are you still menstruating?

	Please describe menses
	Irregular
	Heavy
	Light
	No flow
	Blood clots
	PMS
	Painful periods
	Uterine fibroids

Are you peri-menopausal? Please list symptoms:

Are you menopausal? Please list symptoms:

Respiratory/ENT/Head:

Do you smoke?

How much/day?

for how long?

	Do you, or have you had
<input type="checkbox"/>	Frequent colds
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Cold sores
<input type="checkbox"/>	Bleeding gums
<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	Ringing in ears
<input type="checkbox"/>	Frequent head aches
<input type="checkbox"/>	Migraine

Cardiovascular/Skin/Hair:

	Do you, or have you had
<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	Cold hands/feet
<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	Dry skin
<input type="checkbox"/>	Skin rashes
<input type="checkbox"/>	Itching
<input type="checkbox"/>	Acne
<input type="checkbox"/>	Eczema
<input type="checkbox"/>	Hair loss

Are there any additional health conditions that I should be informed of?

Have you had facial acupuncture before?

Please describe what features of your face you would like to address:

Thank You!!!

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