

Acupuncture Intake Form
Blue Peacock Acupuncture
Erin Dietz L.Ac, LMP
2101 N 55th Suite 120 Seattle, WA, 98103
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)
<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	Allergies: To what?
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	High blood Pressure
<input type="checkbox"/>	Stoke
<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Herpes
<input type="checkbox"/>	Hepatitis A/B/C
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	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

Gastrointestinal:

	Do you, or have you had
	hernia
	ulcers
	Acid reflux
	hemorrhoids
	Constipation: how often?
	Diarrhea: how often?
	Gas: how often?
	Burning: how often?

Energy and Exercise:

Energy level: Please mark with an X where your general energy level falls (1=can't get out of bed; 5= mid-level energy; 10=always full of energy):

1 5 10

How often do you exercise?

What kind of exercise?

Do you perspire during the day (without much physical exertion)?

Do you have trouble waking up in the morning?

Emotions and Sleep:

	Do you, or have you had
	Panic attacks
	Depression
	Anxiety
	Poor Memory
	Difficulty concentrating
	Difficulty falling asleep
	Difficulty staying asleep
	Night sweats

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
	Frequent colds
	Asthma
	Dizziness
	Cold sores
	Bleeding gums
	Dry mouth
	Ringing in ears
	Frequent head aches
	Migraine

Cardiovascular/Skin/Hair:

	Do you, or have you had
	Palpitations
	Cold hands/feet
	Irregular heart beat
	Dry skin
	Skin rashes
	Itching
	Acne
	Eczema
	Hair loss

Have you had acupuncture before?

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

Thank You!!!

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