Acupuncture Intake Form

Name:	
Birth Date:	Email:
Address:	
Daytime Phone:	Referred by:
Occupation:	Physician:

What are the main concerns for your visit? _____

_____

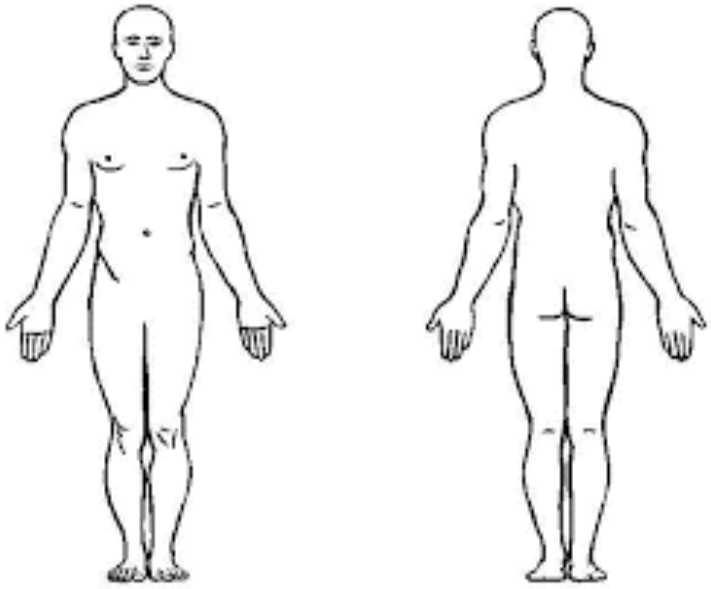
When did the symptoms begin? _____

Do you feel your condition is getting worse? _____

What makes it feel worse? _____

What makes it feel better? _____

Please indicate on the diagram below where you have pain



What other treatments are you receiving for it? _____

Are your symptoms related to a Motor Vehicle Accident? _____

If so, please briefly describe the accident including the date: _____

_____

_____

Please **CIRCLE** what best describes your emotions overall:

◊ Normal ◊ Worry ◊ Irritable ◊ Sad ◊ Anger ◊ Depressed ◊ Anxious ◊ Overthinking

◊ Other: _____

Please **CIRCLE** what best describes your sleep overall:

◊ Normal ◊ Can't fall asleep ◊ Wake up during the night ◊ Restless ◊ Wake up early

◊ Wake up feeling exhausted ◊ Night Terrors ◊ Vivid Dreams ◊ Wake up sweaty

◊ Other: _____

Please **CIRCLE** what best describes your digestion:

◊ Normal ◊ Crave Sweets ◊ Crave Salt ◊Crave Cold Water ◊ Crave Grease

◊ No Appetite ◊ Bloating/Gas after eating ◊ Exhaustion after large meals ◊ Gnawing Hunger

◊ Other: _____

Please **CIRCLE** what best describes your bowel movements:

◊ Normal ◊ Diarrhea after large meals ◊ Constipation ◊ Stool with undigested food ◊ Bloody

◊ Lots of effort, little output ◊ Hard Little Pellets ◊ 1x per day ◊ 2x per day ◊ 3x+ per day

◊ Burning ◊ Foul smelling ◊ Wake up in the morning with Diarrhea

Other: _____

Please **MARK** your level of stress:

Low Stress High Stress

Please list your current medications and dosages:

_____

_____

_____

Please **CIRCLE** the condition(s) and symptom(s) that apply to you:

◊ Addiction
◊ Allergies
◊ Amenorrhea (lack of menses)
◊ Anxiety
◊ Arthritis
◊ Asthma
◊ Bells Palsy
◊ Bleeding
◊ Bloating/Gas
◊ Bruising
◊ Brittle Nails
◊ Cancer
◊ Chest Pain
◊ Constipation
◊ Cold Hands/Feet
◊ Chronic Cough
◊ Chronic Low Grade Fever
◊ COPD
◊ Dental Problems
◊ Depression
◊ Diabetes
◊ Diarrhea
◊ Dysmenorrhea (painful menses)
◊ Dizziness
◊ Dry Eyes/Hair/Skin
◊ Eczema
◊ Edema
◊ Epilepsy
◊ Erectile Dysfunction
◊ Excessive Sweating
◊ Eye Floaters
◊ Gallstones
◊ GERD
◊ Gout
◊ Hemorrhoids
◊ Headaches
◊ Heart Burn
◊ Heart Disease
◊ Heavy Menstrual Flow
◊ Hiccups/Belching
◊ High Blood Pressure
◊ HIV Positive
◊ Hives/Rashes
◊ Insomnia
◊ Infertility
◊ Irritable Bowel Syndrome
◊ Kidney Stones
◊ Leukaemia
◊ Lumps
◊ Low Libido
◊ Migraines
◊ Miscarriages
◊ Muscle Tension
◊ Multiple Sclerosis
◊ Night Sweats
◊ Night Terrors
◊ Osteoporosis
◊ Ankle/Foot Pain
◊ Back Pain
◊ Elbow/Wrist Pain
◊ Hip Pain
◊ Neck Pain
◊ Knee Pain
◊ Shoulder Pain
◊ Pain at Night
◊ Painful Urination
◊ Palpitations
◊ Poor Memory
◊ Poor Sleep
◊ PMS
◊ Reduced Sexual Energy
◊ Ringing in Ears
◊ Sciatica
◊ Seminal Discharge
◊ Shingles
◊ Smoking Cessation
◊ Sores in mouth/lips
◊ STD's
◊ Stroke
◊ Sudden Weight Loss
◊ Tremors
◊ Thyroid Dysfunction
◊ Urine Retention
◊ UTI's
◊ Vaginal Prolapse
◊ Vaginal Discharge
◊ Varicose Veins
◊ Vertigo
◊ Other:

FOR FEMALES ONLY

Do you have a regular menstruation cycle? Clotting during menstruation?

Heavy or Light? Colour?

Pain before, during or after?

What is your mood leading up to your menstruation and during?

Are you dizzy, tired or fatigued before, during or after menstruation?

Do you have a history of UTI's?

Do you use or have used Birth Control? How long?

Have you had problems with Fertility in the past?

History of miscarriages? How many children do you have?

How were the deliveries?

Any history of postpartum depression?

FOR MALES ONLY

Any history of urination problems?

Any history of low back pain? Knee pain?

Any history of infertility, erectile dysfunction, painful erections, seminal emissions?

Last prostate exam?

I hereby provide consent to the performance of Acupuncture and other procedures related to Acupuncture and Traditional Chinese Medicine such as Moxabustion, Cupping, Electro-Acupuncture, Tuina/Massage Therapy, Chinese Herbal Formulas and other techniques and recommendations within the scope of practice. These procedures will be strictly performed by Dr. Jordan Biegler, Registered Acupuncturist and TCMD.

In regards to booking, rescheduling and cancelling appointments, I consent and agree upon the clinic's general cancellation policy of cancelling or rescheduling the appointment 24hr prior to the appointment.
Failure to do so may result in a late rescheduling or cancellation fee as per the discretion of the Practitioner and/or the clinics administrative staff.
Multiple infractions of the above stated may result in termination of the Patient & Practitioner treatment plan and all future treatments as per the discretion of the Practitioner.

I have read the above consent and was given the opportunity to ask questions and have my concerns addressed. By signing below, I agree to the above name procedures and techniques to cover the entire course of treatment for the presented main complaint and any additional or future conditions to which I may seek treatment for.

(patient signature) (date)