Remedy Acupuncture

INJURY REJUVENATION AND PAIN MANAGEMENT

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Name: _____Date: _____
Address:_____
_____
Phone #: _____
Email: _____
DATE OF BIRTH: _____
INSURANCE: _____

Blood Pressure: _____ Temperature: _____
Primary-care Doctor: _____
Phone #: _____

ACUPUNCTURE INTAKE FORM Medical History

1. **Please describe your main reason (chief complaint) for seeking acupuncture treatment and what is your goal for your main reason (chief complaint).**

_____

_____

_____

_____

_____

2. **Please describe any active internal medical problems (e.x: diabetes, fatty liver, asthma, crohn's disease, hypothyroidism, greaves disease, high BP, and arrythmias):**

_____

_____

_____

_____

_____

3. **Please describe any connective tissue pain on the left &/or right side of your body including sprains, strains, contusions, tendonitis, bursitis, recurrent muscular/ fascia tightness, and upper trap pain:**

_____

_____

_____

4. **Please describe any major accidents, surgeries or hospitalizations (e.g., fractures, car accident injury, appendectomy, cesarean section, gall bladder removal, hysterectomy)**

_____

_____

_____

5. **As you feel comfortable, please describe an emotion you feel have been overwhelming in the past 4 weeks and/or check a box that helps describe the emotion.**

_____

_____

_____

- ☐ Nervousness
- ☐ PTSD
- ☐ Stressed
- ☐ Panic attacks
- ☐ Compulsiveness
- ☐ Indecisive
- ☐ Trouble letting go

- ☐ Mood swings
- ☐ Anxiety, fear
- ☐ Sadness
- ☐ Anger
- ☐ Depression
- ☐ Excessive worry/rumination
- ☐ Seasonal Mood disorder

6. **Please list any type of prescribed medication that you are currently taking:**

_____
_____
_____
_____
_____
_____
_____

Social History

1. Are you:

☐ **Never Married** ☐ **Married** ☐ **Partnered/significant other**

☐ **Widowed** ☐ **Divorced** ☐ **Separated**

2. Who lives at home with you? Include any pets.

_____

_____

_____

3. Please describe your current job. (Do you use more mental energy like an office worker or physical energy like a construction worker?)

_____

_____

_____

Lifestyle

1. Please describe any allergies to medications, foods and/or environment:

_____

_____

_____

2. Are you a smoker? ☐ No or ☐ Yes; how much?_____How many years? _____

3. Describe your typical food and check any box that may apply how you feel after you eat.

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

☐ Bad breath (despite good dental hygiene)	☐ Poor appetite	☐ Excessive hunger
☐ Reflux/Heartburn	☐ Food intolerance	☐ Nausea
☐ Significant burping, belching, hiccupping	☐ Getting full easily	☐ Vomiting

4. How much alcohol do you consume? _____Drinks per week

What type? ☐ Beer ☐ Wine ☐ Liquor/mixed drinks

5. How much caffeine do you consume? _____ Drinks per week

What type? ☐ Tea ☐ Soda ☐ Coffee/espresso drinks

6. Describe your activity level, Include information about your exercise routine, if you have one.

_____

_____

Women's Health

1. **Date of last menstrual period: _____ Age menses began: _____**

2. **How many days between periods? _____**

Is there menstrual…

- ☐ **Clotting**
- ☐ **Painful cramping**
- ☐ Unfamiliar scent
- ☐ **Vaginal burning, itching, dryness**

3. **How many days of flow? _____ Is your flow heavy, light, or "my normal"?**

4. **How many pregnancies? ____ Miscarriages: ____ Abortions: ____ Births: ____**

   Living Children: ____

5. **Please describe any problems you are having with your periods or if you are experiencing menopause.**

_____

_____

_____

6. **Please describe what type of contraception you are currently using, if any, and types you have used in the past.**

_____

_____

_____

Circle all that apply. Please include brief description if you answer "Yes"

1. **Most days my energy level is: Low / Adequate / High**
2. **My body tends to feel: Cold / Same as others / Hot / Sensitive to drafts**
3. **I sweat: easily/ very little / relative to activity / spontaneous / while sleeping**
4. **Do you experience headaches, light-headedness, dizziness, or forgetfulness? Yes / No**
5. **Do you experience pain, blurriness, changes in vision, floaters, dryness, itchiness, frequent tearing with your eyes? Yes / No**
6. **Do you have changes in hearing, ringing, or pain in your ears? Yes / No**
7. **Do you experience congestion, runniness, obstruction, bleeding, or a change in your sense of smell in your nose? Yes / No**
8. **Do you have difficulty swallowing, issues with dental health, or change in your voice? Yes / No**
9. **How much water do you drink per day?**
10. **Do you have a high / low / relative level of thirst?**
11. **Are you experiencing shortness of breath, shortness of breath on exertion, or coughing? Yes/ No**
12. **Do you have cardiovascular symptoms such as chest pain, tightness palpitations, easy bruising or bleeding? Yes / No**
13. **Do you experience digestive symptoms such as bloating, gas, heartburn, or pain? Yes / No**
14. **Do you have bowel movements: Daily / 1-2 days / 3+ days?**
15. **Is your stool usually: well-formed and easy to pass / loose / constipated / diarrhea?**
16. **Is your urination: relative to / more than / less than what you drink?**
17. **Do you experience difficulty falling asleep or staying asleep? Yes / No**
18. **How many hours of sleep do you average per night?**
19. **In addition to your chief complaint, are you experiencing pain, numbness, tingling, burning, stiffness, or reduced range of motion or function with your musculoskeletal system? Yes / No**
20. **Do you have any issues with your skin including rashes, dryness, or lesions? Yes / No**
21. **Do you experience any problems with your hair or nails? Yes / No**