Wildwood

Community Acupuncture Intake Form

Date:_____/_____/_____

PATIENT INFORMATION

Name:

Date of Birth (mm/dd/yyyy): / / Gender Identity:

Phone (primary):

Emergency contact: Phone:

E-mail:

Is it okay to email you regarding relevant clinic updates? YES NO

How did you hear about Wildwood Community Acupuncture:

Please complete the following questions as thoroughly as possible:

What condition(s) are your primary concerns?

1)

2)

3)

How is your sleep? _____

How is your digestion? _____

How would you rate your stress levels, from 1 to 10? (10 being the most stressed) _____

Please list any medications or supplements that you take on a regular basis:

_____

_____

_____

Please list any serious accidents, illnesses, surgeries, or chronic health conditions:

_____

_____

_____

Wildwood

Please check any illnesses that have occurred in blood relatives:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer
- ☐ Alcoholism
- ☐ Asthma

Please check conditions you have or have had in the past:

- ☐ Diabetes
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Seizures
- ☐ Kidney infection/stones

Check symptoms you have or have had in the last year:

MENTAL HEALTH / NEUROLOGICAL

- ☐ Depression
- ☐ Difficulty in focusing
- ☐ Dizziness
- ☐ Easily startled
- ☐ Excessive worry
- ☐ Excessive anger
- ☐ Excessive fear
- ☐ Fatigue/tiredness
- ☐ Headaches
- ☐ Loss of sleep/poor sleep
- ☐ Loss or gain of weight
- ☐ Nervousness/irritability
- ☐ Overwhelmed by life

MUSCLE/JOINT/BONES

- ☐ Tremors or cramps
- ☐ Swollen joints

Pain, weakness, numbness in:

- ☐ Fingers/Toes
- ☐ Hands/Feet
- ☐ Arms/Legs
- ☐ Shoulders/Hips
- ☐ Upper/Middle/Low Back
- ☐ Neck

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High or low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid/irregular heart beat
- ☐ Swelling of ankles

Check symptoms you have or have had in the last year:

EYES/EAR/NOSE/THROAT/RESPIRATORY

- ☐ Asthma/wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

GENITO/URINARY

- ☐ Blood/pus in urine
- ☐ Frequent urination

GASTROINTESTINAL

- ☐ Belching, gas or bloating
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Indigestion/Acid Reflux
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting

SEXUAL HEALTH

- ☐ Vaginal discharge
- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow
- ☐ **Could you be pregnant?** _____
- ☐ Erection difficulties
- ☐ Discharge from penis
- ☐ Prostate trouble
- ☐ Sexually transmitted infection
- ☐ Decreased sex drive