Pure Healthcare
and Acupuncture

Initial Acupuncture Intake

Name:_____Date:_____
Address:_____Zip:_____
Phone:_____Cell:_____
email:_____

Sex: ☐M ☐F Birthdate: _____/_____/_____
Relationship status: ☐Single ☐Married/Partnership ☐Divorced ☐Widowed ☐ ☐Separated

Occupation: _____Employer:_____
Spouse/Partner Name: _____
Emergency Contact: _____Phone: _____

Please describe condition(s) for which treatment is sought:
1._____
Date of onset of symptom(s)_____ Severity of symptoms 1-10 (1 mild/10 severe)_____
Have you seen your physician about this condition? ☐ Yes ☐No

2._____
Date of onset of symptom(s)_____ Severity of symptoms 1-10 (1 mild/10 severe)_____
Have you seen your physician about this condition? ☐ Yes ☐No

3._____
Date of onset of symptom(s)_____ Severity of symptoms 1-10 (1 mild/10 severe)_____
Have you seen your physician about this condition? ☐ Yes ☐No

Have you had acupuncture before? ☐Yes ☐No

Please indicate if any of the following apply to you:

Hemophiliac: ☐Yes ☐No	Epilepsy ☐Yes ☐No
Pacemaker: ☐Yes ☐No	Vegetarian/Vegan ☐Yes ☐No
Heart condition ☐Yes ☐No	Lung condition ☐Yes ☐No
Anticoagulant use ☐Yes ☐No	Diabetes ☐Yes ☐No
Stroke/CVA ☐Yes ☐No	Hepatitis ☐Yes ☐No
HIV/AIDS ☐Yes ☐No	Cancer ☐Yes ☐No

Are you pregnant/is there a chance that you are pregnant? ☐Yes ☐No

Lifestyle/Habits:
Please indicate as appropriate:
Exercise:
☐ Mostly sedentary (little to no activity in career/home)
☐ Mild exercise (housework, climb stairs, gardening etc)
☐ Occasional vigorous exercise (moderate manual labor, exercise 4x/week for 30 min)
☐ Extreme exercise (professional athlete, serious amateur athlete, exercise 6-7x/week for >45 min)

Diet:
Are you on a restrictive diet? ☐Yes ☐No
Is your diet physician prescribed? ☐Yes ☐No
Condition diet is meant to treat: _____
Style/Type of diet: _____
# of meals eaten in average day: _____
Do you consider your diet "healthy"? ☐Very ☐Somewhat ☐No

Fluids
Estimated oz of water/day: _____
Caffeine Intake: ☐None ☐Coffee ☐Tea ☐Cola/performance drinks
# of cups/cans per day: _____
Alcohol Consumption:
Do you consume alcohol? ☐ Yes ☐ No
Type of alcohol consumed: _____
# of drinks/week: _____
Tobacco Use:
Do you currently use tobacco? ☐Yes ☐No If no, did you use in the past? _____
Cigarettes: Packs/day_____ Chew: #/day_____ Pipe/cigar#/day_____ # of years used: _____
Recreational Drug Use:
Do you use recreational drugs ☐Yes ☐No
Type of Drug: _____ Frequency:_____

Family/Community:
How often do you see family/friends? ☐1x/week or less ☐2-4x/week ☐>4x/week
Does your spouse/partner discourage you from attending social events? ☐Yes ☐No
Do you feel safe in your home? ☐Yes ☐No

List all Medications, Nutrients and Supplements that you are taking & include dosage:

Supplements/Medications	Dosage	How Long?	Reason	Any side effects?

Allergies:
☐Drug _____
☐Food _____

Other Symptoms/Systems:
Please indicate if you regularly experience any of the following.
Head & Neck:
☐Dizziness ☐Fainting ☐Stiff neck ☐Migraine
☐Headache ☐Enlarged lymph glands
Other: _____

Eyes & Ears:
☐Blurred vision ☐Visual changes ☐Spots/floaters ☐Eye pain
☐Dry eyes ☐Poor night vision ☐Red/burning/itching eyes ☐Earache
☐Decrease hearing ☐Ringing in ears ☐Chronic ear infection ☐Vertigo
Other: _____

Respiratory/Nose:

☐Chronic Cough ☐Coughing up blood ☐Cough with phlegm ☐Difficulty breathing
☐Shortness of breath ☐Wheezing/Asthma ☐Frequent Colds ☐Chronic sinus infection
☐Nasal congestion ☐Bronchitis ☐Hay fever/allergies ☐Nosebleeds
Other: _____

Genital/Urinary:

☐Increased libido ☐Decreased libido ☐Genital lesions/discharge ☐Pain/itching of genitalia
☐Urgent urination ☐Painful/burning urination ☐Frequent urination ☐Blood in urine
☐Unable to hold urine ☐Nighttime urination ☐Bedwetting ☐Kidney Stone
☐Excessive or scant urination
Other: _____

Cardiovascular:

☐Heart palpitations ☐Chest pain/tightness ☐Poor circulation ☐Varicose veins
☐Irregular heart beat ☐Swelling feet/ankles
Other: _____

Mouth & Throat:

☐Bleeding gums ☐Recurrent sore throat ☐Bitter taste in mouth ☐Dry mouth
☐Difficulty swallowing ☐Lump in throat ☐Tongue/Mouth sores/ulcers
Other: _____

Muscles & Joints:

☐Joint pain ☐Body aches/stiffness ☐Generalized weakness ☐Numbness/tingling
☐Joint swelling ☐Joint discoloration ☐"Heaviness" of body/limbs
Other:_____

Skin:

☐Hives/Rashes ☐Acne ☐Dry skin ☐Eczema/psoriasis
☐Bruise easily ☐Itchy skin ☐Spontaneous sweat ☐Brittle/weak nails
☐Night sweats ☐Changes in moles/lumps
Other: _____

Gastrointestinal:

☐Nausea ☐Vomiting ☐Gas
☐Rectal pain/itchiness ☐Hiccups ☐Bloating ☐Bad breath
☐Loose/soft stool ☐Constipation ☐Anal fissures ☐Hemorrhoids
☐Mucous in stool ☐Blood in stool ☐Black stool ☐Laxative use
☐Intestinal pain/cramping ☐Acid reflux/heartburn ☐Alternating diarrhea/constipation
Other: _____

Appetite/Thirst:

☐Exceedingly hungry ☐Poor appetite ☐Hunger w/no desire to eat ☐Specific cravings
☐Excessive thirst ☐No thirst ☐Thirst w/no desire to drink
Temp of drinks most commonly desired: ☐Very cold ☐Tepid ☐Very Hot
Other: _____

Sleep:

☐Sound/restful ☐Trouble falling asleep ☐Trouble staying asleep ☐Difficulty waking up
☐Wake easily/early ☐Dream disturbed ☐Vivid dreaming/nightmares
#of hours of sleep/night_____

Other: _____

Emotions:

☐Relaxed/calm ☐Sad/Grief/depressed ☐Fearful ☐Impatient
☐Angry/Frustrated ☐Forgetful/poor memory ☐Anxious ☐Stressed
☐Manic
Other: _____

General:

☐Cold hands/feet ☐Always feel hot ☐Always feel cold ☐Fever& Chills
☐Recent unexplained weight changes ☐Fatigue

Menses:

Age at first Menses: _____ # of days in cycle_____ # of pregnancies_____ #of live births _____
☐Amenorrhea ☐Dysmenorrheal ☐Excessive flow ☐Scant flow
☐Mid-cycle spotting ☐Cramping ☐PMS ☐Oral Contraceptive use
First day of last period: _____ Approx date/year menopause: _____