Acupuncture Intake Form

Client Information

/ /

Full Name | Date of Birth

Email Address (used to confirm appointments and monthly newsletter only, never given to third party)

Are you: ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed

Emergency Contact Name | Phone Number | Relation

Family Physician | Phone Number

Occupation | Hours Per Week | Length Of Time

Previous Occupations

Where did you hear about Kunlun Mountain Acupuncture?

General Health Information

On a scale of 1 (low) to 10 (high), how stressful is your:

Work __________ Health Status __________ Social/Family Situation __________

Are you satisfied with your primary relationship &/or support system? ☐ Yes ☐ No

What are your primary health concerns (include duration/frequency)?

Please list any other health conditions not covered above:

Are you aware of any activities or triggers that aggravate the conditions listed above? If yes, please describe:

What, if anything, relieves these conditions?

Do you currently or have you, in the past experienced any of the following:

- ☐ Allergies / Asthma / Sinus Infections
- ☐ Emphysema / COPD / TB
- ☐ Anemia / Bleeding / Clotting Disorders
- ☐ Anxiety / Stress Disorders / Depression
- ☐ Arthritis / Joint Swelling
- ☐ Autoimmune Illness
- ☐ Back Pain / Spinal Injuries
- ☐ Bone Disorders / Osteoporosis
- ☐ Broken Bones / Traumatic Injury
- ☐ Bruise Easily / Sensitive to Touch
- ☐ Cancer / Tumors
- ☐ Cardiovascular Disorders/ Heart Disease/ High Blood Pressure
- ☐ Chronic Fatigue / Fibromyalgia
- ☐ Contagious Disease / Blood Borne Pathogens
- ☐ Dentures
- ☐ Depression / Mental Health Disorders
- ☐ Diabetes
- ☐ Digestive Disorders / IBS / GI Ulcers
- ☐ Drug / Alcohol Abuse
- ☐ Epilepsy / Seizure
- ☐ Frequent Headaches / Migraines
- ☐ Gall Stones
- ☐ HIV / AIDS
- ☐ Insomnia / Sleeping Difficulties
- ☐ Kidney Disease or Stones
- ☐ Liver Disease / Hepatitis / Lyme Disease
- ☐ Menstrual Disorders / Infertility
- ☐ Mononucleosis
- ☐ Neurological Disorders / Stroke / Seizures
- ☐ Numbness / Stabbing Pain
- ☐ Parasites
- ☐ Surgery / Extended Hospitalization
- ☐ Thyroid Disorder
- ☐ Varicose Veins
- ☐ Venereal Disease / Herpes
- ☐ Vision Disorder / Contact Lenses / Glasses

Have you ever lived or traveled abroad for a significant length of time? Where/When?

___

Major events in the past 10 years & dates they occurred (births, deaths, marriages, divorce, accidents, major illness, surgery, job changes, miscarriages, and anything else that has greatly impacted your life and/or your health):

___

___

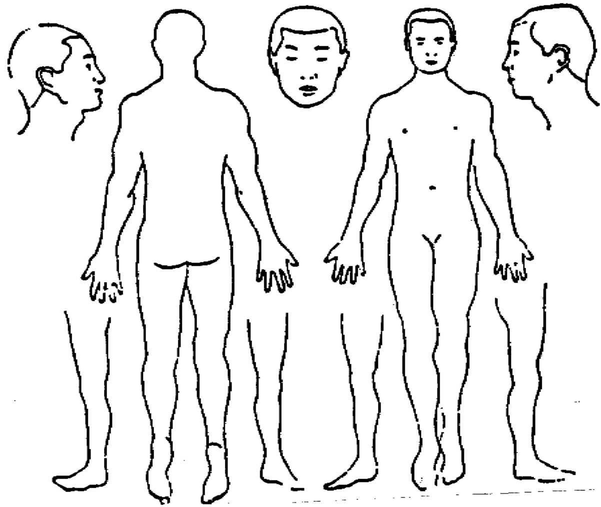
___

___

List all prescription, over the counter and recreational medications, and herbal supplements below:

Name	**Dosage/Frequency**	**How Long**	**Reason**

Please mark all areas of pain/discomfort on the chart below:



Lifestyle Information

Do you use any of the following:

	Past/Present	How Long	Type	Frequency
Tobacco				
Alcohol				
Coffee				
Soft Drinks				
Recreational Drugs				

Women's Questionnaire

At what age did you get your first period: _________ Date of last menstrual cycle? __________________

Are you currently on the Pill? ☐ Yes ☐ No Are you pregnant now? ☐ Yes ☐ No

Pregnancies (please include losses and terminations):

Year	Vaginal or C section	Complications or conditions of note

Have you experienced menopause? ☐ Yes ☐ No If so, when? __________________

If you are experiencing menopausal symptoms, please describe: ____

Please answer the following based on your current menstrual cycle. <u>If you have experienced menopause, please answer based upon symptoms present during the time of your life when menses was present</u>:

Number of days from the start of one period to the start of the next: _________ Spaced regularly? ☐ Yes ☐ No

Average number of days of flow: _________ Flow is: ☐ Light ☐ Normal ☐ Heavy

Color is: ☐ Pale ☐ Normal ☐ Dark ☐ Bright Red ☐ Brown

Are blood clots present? ☐ Yes ☐ No
Does your period cause you pain or cramping? ☐ Yes ☐ No If so, when? ☐ Before ☐ During ☐ After
Do you get nausea or vomiting with your period? ☐ Yes ☐ No If so, when? ☐ Before ☐ During ☐ After
Do you experience any of the following before your period each month? ☐ Water retention ☐ Food cravings
☐ Breast tenderness or swelling ☐ Mental depression ☐ Irritability ☐ Migraines ☐ Other ________________

Do you ever bleed or spot between periods? ☐ Yes ☐ No
Do your bowel movements become loose at the beginning of your period? ☐ Yes ☐ No
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
Have you ever had a cervical biopsy, operation, cauterization, conization? ☐ Yes ☐ No
Have you ever had a venereal disease? ☐ Yes ☐ No
Do you get yeast infections regularly? ☐ Yes ☐ No
Have you ever been diagnosed with uterine fibroids, polyps or endometriosis? ☐ Yes ☐ No
Have you been diagnosed with pelvic adhesions? ☐ Yes ☐ No
Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

---

Men's Questionnaire

Have you been diagnosed with prostate problems? ☐ Yes ☐ No
Have you ever experienced any of the following?

Blood in semen? ☐ Yes ☐ No
Burning on ejaculation? ☐ Yes ☐ No
Low Libido? ☐ Yes ☐ No
Vasectomy? ☐ Yes ☐ No
Pain or swelling of testicles? ☐ Yes ☐ No
Penis discharge? ☐ Yes ☐ No
Painful orgasm/intercourse? ☐ Yes ☐ No
Impotence? ☐ Yes ☐ No

Do you experience premature ejaculation? ☐ Yes ☐ No
Sexually Transmitted Diseases/ Other Disorders: ______________________________

Thank you for taking the time to complete the above questions. By answering, you are helping us better serve you.

Do you have any other concerns not mentioned above: ______________________________

____

____

____

____

______________________________ ____/____/________

Patient Signature Date