Acupuncture Intake Form

_____
Date

_____ _____
Name (Last, First, MI) Date of Birth

Have you had acupuncture before?

☐ Yes ☐ No If yes, please provide name of acupuncturist _____

Please list your major complaints, in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

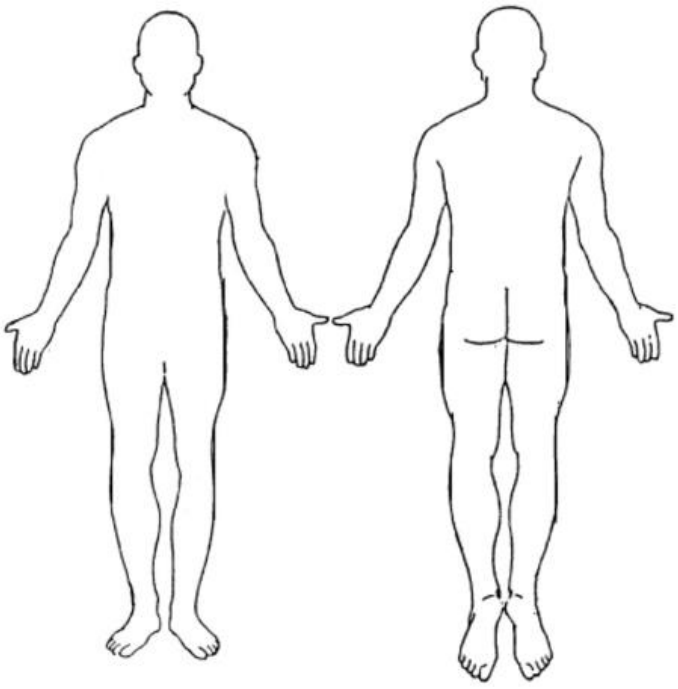
Are you being treated for this condition by anyone else?

☐ Yes ☐ No If yes, please provide name _____

Has this condition been diagnosed by a Medical Doctor?

☐ Yes ☐ No If yes, please provide diagnosis _____

Using the diagram provided below, please indicate areas of pain.



Quality of pain:

☐ Burning	☐ Sharp Pain	☐ Constant
☐ Dull Ache	☐ Sore	☐ Fixed
☐ Cramping	☐ Stabbing	☐ Moves about

What helps the pain?

☐ Ice	☐ Movement	☐ Massage
☐ Heat	☐ Pressure	☐ Nothing
☐ Rest	☐ Moisture	☐ Other

_____

What aggravates the pain?

☐ Ice	☐ Movement	☐ Massage
☐ Heat	☐ Pressure	☐ Nothing
☐ Rest	☐ Moisture	☐ Other

_____