CONFIDENTIAL PATIENT INTAKE FORM

Name:_______________________________________

Phone #_____________________________________

Email:_______________________________________

Address:_____________________________________

Birthdate:____________________Age:___________

Occupation:__________________________________

Physician:____________________________________

Emergency Contact:___________________________

Relationship:____________________________

Phone #_________________________________

Is this your first acupuncture treatment? Yes No

How did you hear about us?

□ You're part of the Desert Song community

□ Website □ Referral □ Print □ Yelp

□ Other:_____________________________________

If patient is under 16 years of age:

Parent/Guardian:________________________________

Signature:________________________ ________________

Phone #_____________________________________

MAIN HEALTH CONCERNS

Please list in order of importance

1.____

MILD 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 SEVERE

How long:____________________________________

Other treatments:_____________________________

What makes it better:__________________________

What makes it worse:__________________________

2.____

MILD 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 SEVERE

How long:____________________________________

Other treatments:_____________________________

What makes it better:__________________________

What makes it worse:__________________________

3.____

MILD 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 SEVERE

How long:____________________________________

Other treatments:_____________________________

What makes it better:__________________________

What makes it worse:__________________________

INJURIES/SURGERIES

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HEALTH HISTORY

Please check current concerns - write P for past

□ Allergies

□ Anemia

□ Anxiety/Panic/Worry

□ Asthma

□ Auto immune disease

type?_____________

□ Cancer

type?_____________

□ Cardiovascular disease

□ Chronic pain

□ Constipation

□ Depression

□ Diabetes

type 1 type 2

□ Digestion problems

□ Edema

□ Eye concerns/floaters

□ Fibromylagia

□ Gall Bladder

□ High Blood Pressure

□ High Cholesterol

□ HIV/AIDS

□ Kidney disorder

□ Lyme Disease

□ Migraines

□ Osteoporosis

□ Pacemaker

□ Seizure disorder

□ Skin condition

□ Sleep Apnea

□ Stroke/TIA

□ Substance abuse

□ Thyroid

Hyper or Hypo

□ Tinnitis

□ TMJ/bruxism/clenching

MEDICATIONS/SUPPLEMENTS/HERBS

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