**Blossom Acupuncture**
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# Patient Health Intake

*CONFIDENTIAL*

Name:___________________________________________Date:_____________

Age:______ Date of Birth:____/____/______ Sex:_____M _____F Marital Status:_______________

Home Address:_________________________________________City:___________________________________

State:_____ Zip Code:____________E-mail:________________________________________________________

Best way to reach you (circle): Home Phone:(_____)______________Cell Phone: (_____)_________________

Employer:_____________________________Occupation:_____________________________________________

If under 18, person responsible for your account? ____________________________________________________

Emergency contact:_________________________Phone:(_____)_______________Relation:________________

Medical Insurance Carrier:______________________________Policy #:___________________________________

Name of your Medical Doctor:___________________________Whom may we thank for referring you?_________

Have you had acupuncture before? Yes / No. With whom?_________________________________________

For what condition(s)_____________________________________________________________________________

Please mark any of the following that apply to you:

___High Blood Pressure ___Blood Thinning Meds ___Pacemaker ___ Seizures ___Pregnancy

Describe the main health concern for which you are seeking treatment:_______________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

| | Mild | | | | Moderate | | | | Severe | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Severity of your complaint today: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Highest to date?_____________ |

When did you first experience these symptoms?________________________________________________________

Was there any trauma relating to the onset of your complaint, and if so please describe?______________________

_____________________________________________________________________________________________

Describe how your complaint affects your daily activities:______________________________________________

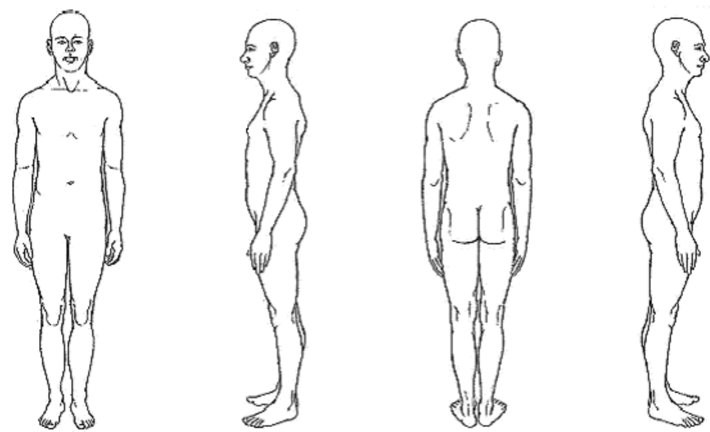
What have you done to address this complaint:__________________________________________________

_____________________________________________________________________________________________

Describe any lab work or imaging you have had done (if any):___________________________________________

**Please mark the areas of discomfort or pain on the figures using the symbol that best describes the feeling.**

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/// Numbness



If you have pain currently, it is:
_____Sharp _____Burning _____Cramping _____Tingly _____Dull _____Aching _____Numb

Which of the following alleviates it?
_____Heat _____Exercise _____Rest _____Dry/hot climate
_____Cold _____Activity _____Pressure _____Damp/cold climate

Which of the following aggravates it?
_____Heat _____Exercise _____Rest _____Dry/hot climate
_____Cold _____Activity _____Pressure _____Damp/cold climate

Is the pain constant? Yes / No If no, when does the pain occur:________________________________________

Does the pain affect your sleep? Yes / No Does the pain radiate? Yes / No If yes, where?_____________

Other comments regarding your pain or main concern today:_________________________________________

__________________________________________________________________________________________
__________________________________________________________________________________________

## Women Only:

**Pregnant?** Yes / No If yes, due date__________Number of children__________

Are you trying to get pregnant? Yes / No Number of pregnancies: ________

Regular Menstrual cycle? Yes / No Avg. number of days of bleeding_______ Avg. length of cycle________

Vaginal discharge? Yes / No Bleeding between periods? Yes / No If yes, please describe__________________

Painful or symptomatic periods? Yes / No If yes, please describe_______________________________________

If applicable, please check the following pre-menstrual symptoms you experience:

___Dull cramping ___Breast swelling ___Hunger/cravings ___Depression
___Sharp cramping ___Bloating ___Low appetite ___Nausea
___Low back pain ___Migraines ___Water retention ___Vomiting
___Breast tenderness ___Headaches ___Irritability

If applicable, please check the following menopausal symptoms you experience:

___Hot flashes ___Sleep disturbance ___Thinning hair
___Vaginal dryness ___Mood swings ___Inc. abdomen fat

Other_________________________________________________________________

## Men Only:

___Benign prostate hyperplasia (BPH) ___Erectile dysfunction
___Urinary difficulty ___Testicular pain
___Urinary pain ___Cold sensation of external genitalia
___Spermatorrhea

Are you currently under the care of a medical doctor or other type of health care provider for any conditions? Yes / No

If yes, for what condition?______________________________________________________________

List any medications you are taking (use the other side if necessary):

| Medication | Dosage | Prescribed By | Reason | Date started |
|---|---|---|---|---|
| | | | | |
| | | | | |

List any allergies or sensitivities:___________________________________________________________

Dietary Supplements (herbs, vitamins, etc.):_________________________________________________

________________________________________________________________________________

Dietary preference: (meat/vegetarian/vegan/other)___________________________#meals you eat/day______________

Please list any other conditions or concerns regarding your health:_________________________________

________________________________________________________________________________

Medical History: Please briefly list major illnesses, traumas, and medical incidents, chronologically (use the back of this sheet if you need more space):___________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Please briefly list your immediate family medical history:_________________________________________

________________________________________________________________________________

________________________________________________________________________________

**The following is a list of some of the many conditions acupuncture effectively treats. Please select any of the following conditions if you would like more information on how we may be able to help.**

___IBS
___Acid reflux
___Nausea/vomiting
___Infertility
___Ovarian cysts
___Hot flashes
___Anxiety
___Depression
___Insomnia
___Fatigue

___Stress
___Asthma
___Arthritis
___Tendonitis
___Sciatica
___Carpal tunnel
___Fibromyalgia
___Common cold
___Flu
___Immune weakness

___Shingles
___Bell's Palsy
___Thyroid disorders
___Stroke rehabilitation
___Bladder infection
___Interstitial cystitis
___Low libido
___Vertigo
___Anemia

___Gout
___Migraines
___Headaches
___Trigeminal neuralgia
___Allergies
___Sinus infections
___Addiction

Other comments or questions: ______________________________________________________________

________________________________________________________________________________

***Please sign and date***

Patient Signature:___________________________________ Date:_____________________

Acupuncturist Signature:______________________________ Date:______________________