Health Luminosity

Acupuncture Intake

Name _____
Address _____
City _____ Zip code _____ Preferred phone _____
☐ Male ☐ Female Age _____ Birth Date _____ E-mail _____

Employment Information

Patient employed by _____ Occupation _____
Business address _____ Business Phone _____

Emergency Information

Notify in case of emergency _____ Emergency phone _____

Reason for Visit

Have you ever seen an acupuncturist? ☐ Yes ☐ No If yes, when and why? _____
Your reason for this visit: _____
Please describe your current symptoms: _____
_____
When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Energy Levels (Please check the following if they **presently** apply to you)

☐ Fatigued, or fatigue easily ☐ Need to take naps ☐ Generally feel cold
☐ Cold feet ☐ Cold hands ☐ Wake up sweating during the night

Appetite and Digestion

☐ Appetite altered recently ☐ Poor appetite ☐ Frequent gas

What percentage of your diet is the following
Animal protein _____ Vegetables _____ Carbohydrates _____ Fruit _____ Sweets _____ Snacks _____
How much caffeine do you have daily? _____
How much alcohol do you drink? _____
List any suspected or known food allergies _____

Thirst and Dryness

☐ Excessive thirst ☐ Dry eyes ☐ Dry nose or lips ☐ Dry skin ☐ Dry hair How many glasses of water/fluids do you drink daily ___

Stools

☐ Normal (daily with the same shape and size) ☐ Unusually hard ☐ Unusually loose
☐ Erratic in form (sometimes hard, sometimes loose) ☐ Bowel movements less than 5 times per week (constipation)

Urine

☐ Wake more than once at night ☐ Dribbling of urine ☐ Urgency to urinate
☐ Burning with urination

Sleep

☐ Trouble falling asleep ☐ Trouble staying asleep

Emotions

Do you experience excessive:

Anger _____ Fear _____ Worry _____ Sadness _____ Depression _____ Anxiety _____

Do you experience mood swings? _____

Are they related to eating or not eating? _____

Do you take mood regulating prescription medications? _____

Muscular Skeletal

☐ Chronic or occasional backache or neck ache

☐ Chronic or occasional joint pain

☐ Muscles ache or cramp

Accidents

Please list all major accidents, including fractures, deep cuts, serious sprains, etc. Please indicate all head injuries. Include dates or age:

_____

_____

_____

Surgeries

Describe the reason, age and any consequential outcome: _____

_____

Exercise

What do you do for exercise? How often? _____

Disease History

Do your parents have any unusual health problems? If deceased, state cause and age of death.

Father: _____

Mother: _____

During your mother's pregnancy with you did she (if you know):

☐ Drink alcohol ☐ Smoke cigarettes ☐ Take medications ☐ Suffer serious illness ☐ Suffer emotionally or physically

Please check if you have or have had any of the following:

Past	Now	Past	Now	Past	Now
☐	☐ Anemia	☐	☐ Food Allergies or Sensitivities	☐	☐ Low sex drive
☐	☐ Arthritis	☐	☐ Frequent colds	☐	☐ Mental illness
☐	☐ Asthma	☐	☐ Gallstones	☐	☐ Mononucleosis
☐	☐ Bruising	☐	☐ Hay fever allergies	☐	☐ Nose bleeds
☐	☐ Cancer	☐	☐ Headaches	☐	☐ Numbness
☐	☐ Candida	☐	☐ Heart murmur	☐	☐ Prostate problems
☐	☐ Cholesterol, high	☐	☐ Heart palpitations	☐	☐ Sciatic pain
☐	☐ Chronic fatigue	☐	☐ Hepatitis: Type _____	☐	☐ Skin problems
☐	☐ Depression	☐	☐ Herpes	☐	☐ TMJ
☐	☐ Diabetes	☐	☐ Hypertension	☐	☐ Thyroid disease
☐	☐ Edema	☐	☐ Hypotension	☐	☐ Ulcers
☐	☐ Epilepsy	☐	☐ Kidney stones	☐	☐ Parasites

Any other serious illness, injuries or complaint? _____

Please list any medications (including pain killers), vitamins or herbal supplements you are taking: _____
_____
_____
_____
_____
_____

Women Only

☐ Amenorrhea (long time spans without a period)
☐ Chronic vaginal or yeast infections
☐ Endometriosis
☐ Irregular Periods
☐ Menstrual cramps
☐ Miscarriage
☐ Ovarian cyst
☐ Pelvic Inflammatory Disease (PID)
☐ Uterine fibroids

Birth control method (past or present); number of years of usage _____

Menstrual history

☐ Pregnant ☐ Menopausal disorder ☐ Completed menopause ☐ Hysterectomy

If you are still having your periods:

☐ Regular Period ☐ Bleed excessively or too little ☐ Ovulation painful ☐ Discharge clots
How many days between your periods? ____
How many days does your period last? _____
Do you get headaches during menstruation or ovulation? ____
Do you suffer from premenstrual syndrome (PMS)? If yes, please indicate: _____
☐ Breast distention ☐ Irritability ☐ Headache ☐ Water retention
How many days before your period do the PMS symptoms begin? _____

Pregnancy history

How many times have you been pregnant? _____
Did you have difficulty getting pregnant? _____
Did you have difficulty following childbirth? _____
The present ages and gender of your living children _____

Men Only

☐ Pain on urination
☐ Unable to hold urine
☐ Premature ejaculation
☐ Frequent urination
☐ Kidney stones
☐ Prostate Problems
☐ Urgency to urinate
☐ Impotence
☐ Wake up at night to urinate

Consent for Treatment

I voluntarily consent to the rendering of care including treatment and performance of diagnostic procedures.

I understand that there are minor risks associated with acupuncture treatment, including but not limited to slight bleeding and/or bruising of the skin. I understand that the risk of infection is negligible when using a single use, disposable needle. Cupping may produce occasional bruising.

I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

Signature of patient _____ Current Date _____
Signature of parent/guardian if patient is a minor _____ Current Date _____