Acupuncture For Athletics

Acupuncture Intake Form

Name:_____Today's date:_____

Address:_____Age:_____DOB:_____

City:_____zip_____State_____

How did you hear about us?_____

Phone:_____ Cell:_____ Marital Status:_____

Emergency contact:_____

Relationship:_____ Phone:_____

Main problem you would like help with_____

_____

When did it begin? (please be specific)_____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

Past Medical History

____Cancer	____Thyroid Disease	____Venereal Disease
____Diabetes	____High Blood Pressure	____Rheumatic Fever
____Hepatitis	____Heart Disease	___Other_____

What types of surgeries have you had and when?_____

_____

Any traumas, accidents or injuries?_____

Allergies? (drugs, chemicals, food etc.)_____

Family Medical History

____Cancer	____High Blood Pressure	____Heart Disease
____Diabetes	____Stroke	____Seizures
____Asthma	____Allergies	____Other_____

What medications and/or supplements are you currently taking and for what?_____

_____

Are you experiencing any of the following?

General

____Recurrent infections ____Night sweats ____Sweat easily ____Fatigue

____Bleed or bruise easily ____Strong thirst (hot or cold) ____Thirst w/ no desire to drink

____Sudden energy drops (____time of day) ____Poor sleep ____Poor balance ____Tremors

____Edema ____Underweight ____Overweight

Skin

____Rashes ____Itching ____Eczema ____Psoriasis ____Oozing ____Pimples

____Dry skin/scalp ____Recent Moles ____Changes in hair/skin ____Other_____

Head/Eyes/Ears/Nose/Throat

____Headaches ____Migraines ____Dizziness ____Discharge from ear ____Ringing in ears

____Blurry vision ____Night Blindness ____Color Blindness ____Spots in front of eyes ____Eye pain

____Excess tearing ____Sore eyes ____Facial pain ____Nose bleeds ____Grinding teeth

____Nasal Discharge ____Blocked nose ____Snoring ____Teeth problems ____Tonsillitis

____Swollen glands ____Sore lips/mouth ____Poor Hearing ____Other_____

Cardiovascular

____Pacemaker ____High blood pressure ____Low blood pressure ____Fainting ____Spider veins

____Chest discomfort/pain ____Heart palpitations ____Cold hands/feet ____Blood clots

____Swelling of hands/feet ____Other_____

Respiratory

____Difficulty breathing ____Pain with breathing ____Shallow breathing

____Shortness of breath ____Production of phlegm ____Recurrent cough ____Asthma

____Bronchitis ____Pneumonia ____Wheezing ____Other_____

Digestive

____Bad breath ____Change in appetite ____Nausea ____Vomiting ____Heartburn

____Indigestion ____Belching ____Abdomen pain/cramps ____Loose stools ____Gas

____Weight gain ____Weight loss ____Diarrhea ____Strong smelling stools

Bloody stools Pale stools Black stools Rectal pain Bulimia

____Constipation ____Pain with passing stools ____Hemorrhoids ____Anorexia Nervosa

Urinary

____Pain with urination ____Urgency with urination ____Frequent urination ____Blood in urine

____Decrease in urinary flow ____Unable to hold urine ____Incontinence at night ____Dribbling

____Kidney stones ____Rashes ____Prostate problem ____Changes in sex drive ____Impotency

____Do you wake at night to urinate? How many times?____ ____Other_____

Gynecological

____# of pregnancies ____# of live births ____Breast lumps ____Age of menopause

____Date of last PAP ____PMS ____Irregular menstruation ____Painful menstruation

____Light menstruation ____Heavy menstruation ____Blood clots ____Fibroids

____Endometriosis ____Infertility ____Post-coital bleeding

____Other_____

____Do you practice birth control? What type and how long? _____Are you pregnant now?____

Musculoskeletal

____Neck ache/pain ____Backache/pain ____Knee ache/pain ____Shoulder pain

____Elbow/forearm pain ____Hand/wrist pain ____Foot/ankle pain ____Hernia

____Joint/bone problems ____Torn tissue ____Prostheses____Muscle pain/weakness

____Other_____

Neurological

____Seizures ____Nerve damage _____Paralysis ____Numbness ____Tingling ____Stroke

____Sleep disorder ____Concussion ____Vertigo ____Lack of coordination ____Loss of balance

____Poor memory ____Difficulty concentrating ____Other_____

Behavioral

____Vacant ____Moody ____Aggressive/bad temper ____Easily susceptible to stress

____Anxiety ____Panic attacks ____Depression ____Fear ____Substance abuse

____Other_____

Have you had any courses of antibiotics recently? ____Many ____A few ____1 or 2 ____None

Do you have a regular exercise program?

_____Are you, or have you been on a restricted