ACUPUNCTURE INTAKE FORM

Name:______________________________ Date:______________

Date of Birth:______________ Age:______ Preferred Pronouns (he/she/they/etc):______________

Address:______________________ City:____________ State:_____ Zip:_______

Phone:______________ Email:______________________________

Occupation:______________________ Referred by:______________________

✦Are you using insurance today? Yes / No ✦Is this your first acupuncture treatment? Yes / No

✦Are you currently under the supervision of a medical doctor for the condition you are seeing us for? Yes / No

Physician's Name & Phone Number:______________________________

Emergency Contact Information:______________________________
(Name/Number/Relationship)

Reason for today's visit:______________________________

☐ **I have read** and understand Shen Shen's business policies, including COVID-19 guidelines, the cancellation policy, and HIPAA. I acknowledge I can access the policies via the Shen Shen website and/or ask the business for a physical or digital copy at any time.

☐ **I have not read** but understand by making an appointment I am subject to the COVID-19 guidelines and cancellation policy. I acknowledge I can access the policies via the Shen Shen website and/or ask the business for a physical or digital copy at any time.

Family History	IF LIVING		IF DECEASED	
	AGE	HEALTH Good / Fair / Poor	DEATH AGE	CAUSE OF DEATH
Father				
Mother				
Sibling (Circle Sex)				
1. M F				
2. M F				
3. M F				
Spouse/Partner				
Children (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				

Have you or any blood relatives had any of these conditions?

	Yes	No	Self or Relationship		Yes	No	Self or Relationship
Asthma				Hay Fever			
Arthritis				Kidney Disease			
Allergies				Leukemia			
Anemia				Mental Illness			
Alcoholism/Addiction				Migraine			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease				Other (please list)			

HABITS **Daily OR Weekly Consumption**

Do you smoke? Y / N ______________________

Drink Coffee? Y / N ______________________

Drink Alcohol? Y / N ______________________.

Fall Asleep Easily? Y / N

Awaken Early? Y / N

WHAT MEDICATIONS & SUPPLEMENTS ARE YOU CURRENTLY TAKING?

____

____

____

____

Operations, Hospitalizations, Injuries, or Serious Illness you have had: (Year)

____

____

____

____

____

____

ALLERGIES:

____

____

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____

____

Do you exercise regularly? Y / N

If Yes, How Often?_________________

What Type of Exercise?

____

____

____

____

WOMEN ONLY (AFAB) - Please check all that apply:

Are you still having regular monthly periods? Y / N

☐ Bleeding between periods?
☐ Discharge
☐ Heavy Bleeding
☐ Bloating ☐ Gas
☐ Headaches?
☐ Low Back Pain?
☐ Cramping?

☐ Depression
☐ Irritability
☐ Miscarriage: If yes, how many?__________
No. of children born alive?___________
No. of stillbirths? _________
Complications with pregnancy? Y / N

☐ Use/Used birth control
How many days of flow? ______
How many days cycle? _____
☐Brownish Blood
☐ Clotting
☐ Dark purple blood

******* Are you or do you suspect that you might be pregnant now? Yes / No** **If yes, how many months? __________**

MEN ONLY (AMAB) – Please check all that apply:

☐ Loss of sexual activity
☐ Discharge from penis
☐ Treatment for genitals
☐ Hernia (rupture)
☐ Prostate trouble
☐Other? ____

MEN AND WOMEN – Please check all that apply:

☐Headaches
☐Dizziness
☐Ringing in the ears
☐Blurred vision
☐Stuffy/Runny Nose
☐Coughing / Wheezing
☐Sore throat
☐Acid Reflux / Heartburn
☐Bad taste in mouth
☐Bleeding gums

☐Chest tightness
☐Shortness of Breath
☐Palpitations (feeling heartbeat?)
☐Pain in calves
☐Tingling in legs at night
☐Blood in urine
☐Kidney stones
☐Difficult or frequent urination
☐ Diarrhea
☐Constipation
☐Pain in abdomen

☐Mucous in stool
☐ Undigested food in stool
☐Excessive Thirst
☐Low Thirst
☐Excessive Appetite
☐Low Appetite
☐Recent Weight Gain
☐Recent Weight Loss
☐Cold Hands & Feet

☐Trouble sleeping
☐ Anxiety-filled dreams
☐ Low Back Pain
☐Fatigue
☐Sweating other than with exertion
☐Numbness? Where?___________

Is there anything else you want to add?

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