Five Element Acupuncture - Intake Form
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518.572.4037

Name: _____ DOB / AGE: _____

Mailing Address: _____

City, State, Zip: _____

Phone (Home): _____ (Mobile): _____

E-Mail: _____

Please indicate how you would like to be contacted (circle one): Home phone / Mobile / Text / Email

Emergency contact(s) (name and number): _____

Who may I thank for referring you? _____

Drs. or Practitioners you would like me to consult with: _____

_____

Please list ALL prescription and non-prescription drugs (ie. over the counter, vitamins, supplements, herbs, etc.) currently being taken. Include any that you take occasionally, such as aspirin for headaches, as well as those taken daily. (Use back of page if needed.)

Name	Dose and how often	Reason for taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you chosen to have the following injections? If yes, how many and last received:

C19 shot: How many? Last received?

Flu shot:

Shingles shot:

What is the primary reason you would like to address with acupuncture?

Secondary reasons you would also like to address?

Level of stress and/or anxiety on a scale from 1-10 (10 being the most stressed /anxious): _____

Have you experienced stress that was too overwhelming for your system to handle (physical, emotional, mental trauma)? If yes, the year(s) and share about the experience(s) if comfortable doing so:

Do you tend to feel hot or cold and/or experience hot flashes or chills? If yes, please explain:

Do you experience numbness and/or tingling in any part of your body? Do your feet and/or hands tend towards cold? If yes, please explain:

Do you get headaches on a regular basis? If so, where does it occur in or on your head, and what does it feel like?

Do you have allergies to foods, products, and/or environments? Is it seasonal or daily?

(*For the following set of questions please circle the best response(s), or write N/A if it doesn't apply.*)

Nose: Congestion / Runny / Decreased sense of smell

Eyes: Issues with vision / Floaters / Dryness / Redness / Itchy

Ears: Ringing / Loss of hearing / Extra sensitive to sounds

Do you experience dizzy spells? Yes / No

Chest: Tightness / Pain / Shortness of breath / Palpitations

Pain or discomfort along the sides of your body? Yes / No

Cough: Daytime or nighttime or both / Dry / Phlegm-producing / Difficult to bring up phlegm

What color, if any, is the phlegm? Clear / White / Yellow / Brown / Green

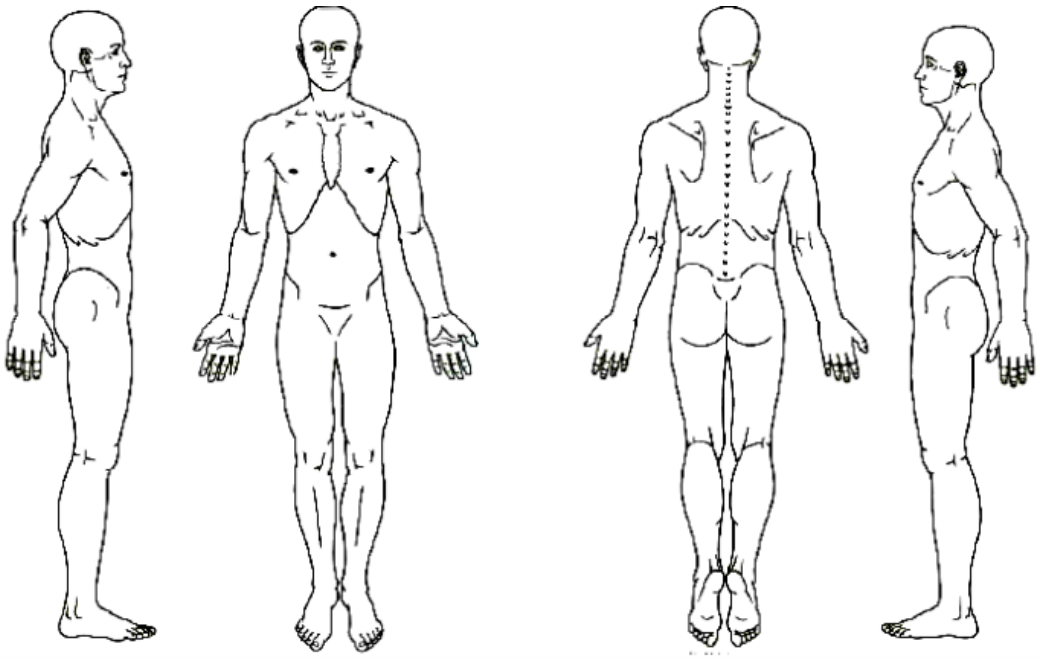
Do you smoke tobacco? Past use? Yes / No **Present use?** Yes / No

If Yes, for how long and/or how often per week? _____

Abdominal Pain:

- **Location of pain (if any):** Mid abdomen / Lower abdomen / Both
- **Related to food intake?** Yes / No / Sometimes
- **What does the pain feel like?** Dull / Sharp / Like a spasm
- **What makes it feel better?** Pressure / Heat / Cold / Other (please explain)

Using the key, please indicate areas of physical issues (both past and current) on the diagram below. List each on next page along with a brief description and dates they occurred.



O	PAIN
X	BROKEN BONE
///	WEAK AREA
$	SURGERY

Teeth and gums:

- **Overall health of teeth and gums?**
- **Number and type of filling(s)?**

Energy level: (Use a scale of 1-10, 10 indicating having enough energy to get through your day easily with some left over.)

- **Overall:** _____
- **Upon awaking:** _____
- **Times of day of peaks and low ebbs:** _____

Appetite:

- **Do you get hungry during the day?** Yes / No
- **Do you feel like you eat too much or too little?** Yes / Too much / Too little / No
- **Do you feel energized after eating or feel like you need a nap?** Energized / Nap

Digestion: Bloating / Pain after eating / Frequent gas / Heartburn / Reflux

Diet: *What does a typical day look like?*

- **Breakfast:**
- **Snack:**
- **Lunch:**
- **Snack:**
- **Dinner:**
- **Snack:**

Fluid Intake:

- **How much 8 oz. glasses of water do you drink in a day?** _____
- **Do you get thirsty?** Yes / No
- **How many cups of coffee do you drink in a day?** _____
- **What kinds of soda do you drink and how often?** _____
- **What other kinds of beverages (including alcohol) do you drink and how often?**

  _____
- **Do you consume "diet" drinks with sugar substitutes?** Yes / No
- **What temperature do you prefer your drinks to be?** Cold / Room temp / Warm / Hot

Bowels:

- **How many times a day do you go?**
- **Any difficulty in going?**
- **Any pain?** Yes / No **If Yes:** Before / During / After
- **Any blood in your stool?** Yes / No / Sometimes
- **Any itchiness?** Yes / No / Sometimes
- **Stool description(s):** Well formed / Soft / Tend toward diarrhea / Tend toward constipation

Urination:

- **Do you feel your output is about equal to your input?** Yes / No
- **Any dribbling?** Yes / No
- **Incontinence?** Yes / No
- **Any blood in your urine?** Yes / No
- **Does it ever burn?** Yes / No
- **Color of urine?** Clear / Light yellow / Yellow / Dark yellow

Menstruation:

- **Age of onset:**
- **Number of days in cycle (on and off):**
- **Color:**
- **Clots?** Yes / No **If Yes, what size?** Pea / Dime / Quarter / Other: _____
- **Pain (before or during the bleed):**
- **Breast tenderness:** Yes / No / Sometimes
- **Other PMS symptoms:**

Pregnancy:

- **Number of pregnancies:**
- **Number of births:**
- **Health during pregnancy:**
- **Labor and delivery:**
- **Postpartum:**

Prostate:

- **Have you had a prostate exam?** Yes / No
- **Any concerns?** Yes / No **If yes, please explain:**

Exercise: Type and frequency of movement / exercise:

Sleep:

- **What time do you go to sleep?**
- **What time do you wake?**
- **Difficulty:** Falling asleep / Staying asleep / Waking early, unable to get back to sleep
- **Dreams:** Vivid dreams / Nightmares / I don't dream

Memory:

- **Issues with your memory?**
- **"Foggy" brain or "fuzzy" thinking?**