Knewtson Health Group

Acupuncture & Traditional Chinese Medicine Intake Form

_____ ____/____/____

Name Today's Date

_____ _____

Gender Pronouns (she, he, they, etc)

_____ _____

Address City/State/Zip

(___)_____ (___)_____ _____

Cell phone Home phone email address

_____

Emergency Contact (name, relationship, phone number)

Treatment History

Have you had acupuncture before? ____ yes ____ no

What are your main concerns:

_____

_____

Have you been seen by a MD for these conditions? ____ yes ____ no

What treatments have you received for these conditions?

_____

_____

Pregnancy History (if it pertains)

Are you currently pregnant? ____ yes ____ no

How many pregnancies have you had? _____

How many pregnancies did not come to term? _____

Additional Information:

_____

_____

_____

_____

Contraceptive/Sexual History

Do you use contraceptives? ____ yes ____ no

If yes, what kind, and how long?

_____

Do you have any concerns of sexual nature?

_____

_____

_____

_____

Menstrual Health (if it pertains)

When was your last cycle? ___/___/___ (date of day one)

Usual cycle length: _____ (Length from day one to day one, ex. 28 days)

Does your cycle come regularly or irregularly? (Circle one)

Check all that apply: Past or Present	
Heat/Cold	
Body runs cold	
Body runs warm	
Spontaneous sweating	
Night sweat	
Hands/feet sweat	
Head/face	
Headache	
Migraine	
Dizziness/vertigo	
Lightheadedness	
Eye pain or redness	
Eye swelling	
Dry eyes	
Itchy eyes	
Floaters in vision	
Tinnitus/ringing in ear	
Deafness	
Muscles/Joints	
Neck pain	
Back pain	
Weakness	
Numbness/tingling	
Tremors	
Elimination Bowels/Urine	
Alternating loose stool/constipation	
Loose stools	
Hard stools	
Constipation	
Difficult evacuation	
Sticky bowels	
Blood in stool	
Black stool	
Pain in anus	
Burning anus	
Frequent urination	
Urgent urination	
Scanty urination	
Painful urination	
Digestion/Appetite	
Acid reflux	

Kidney stones	
Prostate enlarged	
Penile discharge	
Erection difficulties	
Mood/Emotion	
Relaxed and calm	
Sad	
Fearful	
Depressed	
Angry	
Irritated easily	
Anxious	
Stressed	
Overthink	
Worry	
Forgetful	
Grief or loss	
Nervousness	
Overwhelmed	

Is there anything else you want your provider to know?

I understand that there are treatments available for my condition other than acupuncture procedures, and that I have the right to seek a second opinion and to secure other options about my circumstances and healthcare as I see fit. I understand that acupuncture is not intended to be a substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend for this consent form to cover the entire course of treatment for my present condition and any other future condition for which I seek treatment.

Please circle:

I DO / I DO NOT have a pacemaker or cardiac device

I DO / I DO NOT have a bleeding disorder

I DO / I DO NOT have a seizure disorder

I HAVE / I HAVE NOT been examined by a physician for my main area of concern

Date of Birth _____/_____/_____

PATIENT NAME (PRINTED)

_____

PATIENT SIGNATURE (or authorized representative)

_____

DATE: _____/_____/_____

PRACTITIONER SIGNATURE

_____

DATE: _____/_____/_____