Gig Harbor Acupuncture & Holistic Health
2703 Jahn Ave NW Suite C4+C5, Gig Harbor, WA 98335 * 253-432-4398

CONFIDENTIAL ACUPUNCTURE INTAKE

Legal Name (last, first, middle initial): ________________________________ **Date:** _____ / _____ / _____

Birth Date: _____ / _____ / _____ **Age:** ______ **Patient sex:** □Male □Female

Street Address: ______________________ **City:** ______________ **State:** ________ **Zip:** _________

Home Phone: (____) ___________ **Mobile Phone:** (____) ___________ **Email Address:** ____________________

Employer: ______________________ **Occupation:** ______________________

Emergency Contact Name: ______________________ **Emergency Contact Phone:** (____) ____________

Please check appropriate box: □Single □Married □Partnered □Divorced □Widowed □Separated

Referred By: ____________ **Physician:** ______________________ **Permission to consult with your physician?** Yes No

CHIEF COMPLAINT: ____

____

When / how did this start: ____

Symptoms: ____

____

List any other Doctors or Therapists you have seen for this condition:

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Recommendations: ____

Treatment(s) received: ____

Are symptoms: Better Worse Unchanged (please circle one)

What makes symptoms worse? ____

What makes symptoms better? ____

Symptoms experienced what percentage of time during a day? 0-25% 26-50% 51-75% 76-100% Other: ______________

List previous accidents or injuries (auto, work, falls, etc.) including dates: ______________________

____

List any previous surgeries, including dates: ______________________

____

____

List all medications (prescription / non-prescription meds, supplements, herbs), **dosage, and when you started/stopped each med:**

____

____

____

Habits	Never	Rarely	Occasionally	
Coffee:	□	□	□	Weekly/Daily Amount: ______________
Black tea:	□	□	□	Weekly/Daily Amount: ______________
Soda:	□	□	□	Weekly/Daily Amount: ______________
Tobacco:	□	□	□	Weekly/Daily Amount: ______________
Alcohol:	□	□	□	Weekly/Daily Amount: ______________
Laxatives:	□	□	□	Weekly/Daily Amount: ______________
Aspirin/NSAIDS:	□	□	□	Weekly/Daily Amount: ______________

Exercise: (please describe type/amount) ____

Stress management tools: ____

Health Goals:

____

____

By signing below, I indicate the information on both front and back of this page is complete and accurate to the best of my knowledge at this time.

______________________________________ ______________________

Patient Signature (if minor, parent or guardian must sign) Date

Current Health Condition (please circle symptoms which have occurred in the past 6 months)

Energy, Immunity, and Metabolism

Fatigue	Catch colds easily	Allergies	Feeling hot/flushed
Energy drops	Slow wound healing	Sweat easily	Fever/chills
General weakness	Chronic infections	Day/night sweats	Recent weight gain/loss

Head, Eyes, Ears, Nose, and Throat

Headaches/migraines	Photosensitivity	Sinus problems/snoring	Sore throat/swollen glands
Dizziness/vertigo	Eye strain/pain/floaters	Nasal congestion	Hoarseness/loss of voice
Vision changes/blurriness	Ear ringing/earaches	Nosebleeds	Teeth grinding

Respiratory and Cardiovascular

Asthma/wheezing	Cough	Palpitations	Varicose/spider veins
Difficulty breathing	Chest tightness/pain	High/low blood pressure	Fainting
Phlegm	Cold hands or feet	High cholesterol	Fluid retention/edema
Pneumonia	Bronchitis	Blood clots	History heart attack/stroke

Gastrointestinal

Low/excessive appetite	Heartburn/acid reflux/ulcers	Dental/gum problems	Diarrhea/loose stools
Difficulty chewing/swallowing	Strong thirst	Abdominal pain/cramps	Constipation
Bad breath	Belching/hiccups	Intestinal gas/bloating	Hemorrhoids/rectal pain
Nausea/vomiting	Gallbladder stones	Food/drug allergies? ___________________________________	

Bowel Movements

Frequency: _______ Blood/mucous in stool Incomplete feeling/pain/urgency Undigested food

Consistency: well-formed dry hard pellets loose soft sticky alternating

Color: brown white/chalky green yellow orange

Genitourinary

Pain/urgency/burning	Frequent urination	Kidney stones	Change in sex drive
Nighttime urination	Profuse/decreased urination	Urinary retention	Incontinence/dribbling
Blood in urine	Urinary tract infections	Bed wetting	Herpes/STDs/genital sores

Skin, Hair, and Nails

Dry skin/scalp/dandruff	Itching/eczema/psoriasis	Rashes/hives Acne/sores	Easy bruising
Weak/brittle/ridged nails	Scars/moles	Hair loss/thinning	

Neurological and Musculoskeletal

Muscle weakness	Lack of coordination/balance	Muscle spasms/tics/tremors	Numb/tingling/paralysis
Seizures/epilepsy	Poor concentration/memory	Slurred speech	Concussion/TBI/Stroke

Pain: Yes No Describe location of pain: ____

Sleep

Difficulty falling/staying asleep	Vivid dreams	Nightmares/night terrors	Sleep talking/walking
Tired upon waking	Restlessness	Avg hours of sleep: _______	Typical bedtime: _______

Emotions

Mood swings	Nervous/anxiety/panic attacks	Frequent worrying/fear	Depression
Seasonal affective disorder	Sadness/tearfulness	Irritability/anger/frustration	Obsessive/compulsive
Mania/elevated mood	Describe your level of happiness____		

Men Only

Prostate disease	Testicular pain/swelling	Low/excessive sex drive	Premature ejaculation
Hernia	Impotence	Difficulty reaching orgasm	Nocturnal emissions
Poor sperm motility	Irregular morphology	Low sperm count	# of children: _________

Women Only

Hot flashes/flushing	Facial hair growth	Fibroids/cysts/PCOS	Endometriosis
Abnormal vaginal discharge/odor	Nipple discharge	Breast tenderness/lumps	Vaginal dryness
Infertility	Spotting between periods	Difficulty reaching orgasm	Pain during intercourse

First day of last menstrual period: __________ Duration of menstrual cycle (ex: 28 days): __________

Duration of period (ex: 5 days): __________ Date of last PAP/pelvic exam: __________

Age of **1st** period: ______________ Are cycles regular? Yes No Any abnormal exam results? __________

PMS symptoms: _______________ Birth control? Yes No Type: __________

Is there any possibility that you are currently pregnant? Yes No Number of pregnancies: _____ Live births: _____

Miscarriages: _____ Abortions: _____ Have you experienced menopause? Yes No If so, when? __________

Please describe menopausal symptoms: ____