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POINTZ Community Acupuncture
Intake Questionnaire

Date _____

Name: _____ Phone: _____

Address: _____ Cell: _____

City, State, Zip _____ Work: _____

D.O.B. _____ Age _____ E-

Mail: _____

Occupation: _____ Would

you like to receive our newsletter? Y N

Employer _____

Emergency Contact Information:

Primary M.D. _____ Name: _____

M.D. Phone: _____

Relationship; _____

Have you ever had acupuncture before? Y N Phone: _____

Are you, or may you be pregnant? Y N

How did you hear of us? _____

HEALTH HISTORY

Please state your **3 primary health concerns** below and rate the severity of each on a scale of 1-10 (1 = little, 10 = extreme). Δ=**change**

1. _____
Severity (1-10):___ Time problem has persisted: _____
How does each of the following affect the problem?

	Better	Worse	No Δ
Heat	☐	☐	☐
Cold	☐	☐	☐
Dampness	☐	☐	☐
Movement	☐	☐	☐

2. _____
Severity (1-10):___ Length problem has persisted:_____
How does each of the following affect the problem?

	Better	Worse	No Δ
Heat	☐	☐	☐
Cold	☐	☐	☐
Dampness	☐	☐	☐
Movement	☐	☐	☐

3. _____
Severity (1-10):___ Length problem has persisted:_____
How does each of the following affect the problem?

Check ALL that apply (both CURRENT & PAST):

	You	Family History
AIDS / HIV	☐	☐
Addictions	☐	☐
Allergies	☐	☐
Anemia	☐	☐
Asthma / C.O.P.D.	☐	☐
Arthritis	☐	☐
Bleeding Disorder	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Hepatitis A, B, or C	☐	☐
High Blood Pressure	☐	☐
Herpes	☐	☐
Kidney Disease	☐	☐
Mental Illness	☐	☐
Pacemaker	☐	☐
Osteoporosis	☐	☐
Seizures	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Shingles	☐	☐
STD	☐	☐

	Better	Worse	No Δ
Heat	☐	☐	☐
Cold	☐	☐	☐
Dampness ☐	☐	☐	
Movement	☐	☐	☐

do you use the following:

List all surgeries, accidents, fractures, serious injuries & hospitalizations:

exercise _____

_____

energy level (1 = low, 10 = high):

_____

3 4 5 6 7 8 9 10

HABITS

How often & in what amounts

Caffeine _____

Nicotine: _____

Alcohol: _____

Drugs: _____

How often do you

What type of exercise? _____

Rate your average

(circle one) **1 2**

List any and all **Medications, Birth Control, HRT, Herbs, or Supplements** you are currently taking:

Name: Reason:

Name: Reason:

_____ _____

_____ _____

_____ _____

Check ANY symptoms that you CURRENTLY HAVE or HAVE HAD IN THE PAST YEAR:

MUSCLE / JOINTS / TENDONS / BONES:

□ Swollen joints
□ Cramps or Spasms
□ Tremors
□ Other _____
TYPE OF PAIN_____
(burning, aching, sharp, stabbing, heavy, etc.)

PAIN, NUMBNESS, OR WEAKNESS in:

□ Hands / Wrist □ Back □ Feet / Ankles
□ Arms □ Legs □ Jaw / TMJ
□ Shoulders □ Hips
□ Neck □ Knees

EYES, EARS, NOSE, THROAT ONLY

□ Blurred / Failing vision
□ Red eyes
□ Itchy/Dry eyes
□ Spots in front of eyes
□ Ringing in ears
□ Earache
□ Loss of hearing
□ Sinus congestion
□ Nosebleeds
□ Hay fever / Allergies
□ Frequent colds
□ Sore throat
□ Cough
□ Phlegm Color_____
□ Hoarseness
□ Dry mouth/throat
□ Mouth sores / Canker sores

TEMPERATURE

□ Cold hands or feet
□ Chills
□ Hot flashes
□ Fever or heat sensations
□ Sweating

CARDIOVASCULAR ***(circle to specify)***

□ Angina / Chest pain
□ Arteriosclerosis
□ Heart Attack / MI
□ High/Low blood pressure
□ High cholesterol
□ Irregular/Rapid heartbeat
□ Palpitations
□ Poor circulation
□ Swollen ankles / Congestive Heart Failure

GENITO/URINARY

□ Blood/Pus in Urine
□ Frequent urination → □ Scant amount □ Profuse amount
□ Incontinence or unable to control urine
□ Kidney infection / Kidney stones

EMOTIONAL SYMPTOMS

□ Anger / Irritability
□ Anxiety / Nervousness
□ Depression
□ Easily startled / Indecisive
□ Excessive Fear
□ Excessive Grief
□ Excessive Worry
□ Forgetfulness, difficulty in focusing
□ Mania / Hypomania
□ Suicidal thoughts

GENERAL ***(circle to specify)***

□ Insomnia / Poor sleep / Awaken early
□ Headaches / Migraines
□ Dizziness / Vertigo
□ Fatigue / Tiredness
□ Excessive Thirst

SKIN ***(circle to specify)***

□ Acne / Boils / Cysts
□ Bruise easily
□ Dry skin / Hair and/or Nail problems
□ Itching / Rash / Hives
□ Eczema
□ Night / Day sweating

GASTROINTESTINAL ***(circle to specify)***

□ Belching / Bloating / Gas
□ Colitis / Colon problems / IBS
□ Constipation
□ Diarrhea
□ Bloody stools
□ Difficulty swallowing
□ Distention of abdomen
□ Excessive hunger
□ Gall bladder problems
□ Hemorrhoids
□ Indigestion / GERD / Acid reflux
□ Nausea
□ Pain in stomach area
□ Poor appetite

FOR MEN

□ Erection difficulties / Impotence
□ Hernia / Groin pain
□ Penis discharge
□ Premature ejaculation
□ Prostate problems

FOR WOMEN ONLY

Age of first menses:_____
Days between menses:_____
Number of pregnancies:_____
□ Miscarriage(s)
# of miscarriages (*if applicable*):_____
□ Clots in menses
□ Bleeding between periods
□ Irregular cycles
□ Menopausal symptoms
□ PMS
□ Light periods
□ Heavy periods
□ Painful periods
□ Spotting / Scanty flow
□ Yeast infections
□ Other: _____

□ Low libido
□ Other:_____
Other:_____

□ Vomiting
□

All information on this form is correct to the best of my knowledge.

Signature:_____

Date:_____