Health Intake Form

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Personal Information

Name_____ Date_____

Birthdate_____Age_____Gender/PGP_____Occupation_____

Home Address_____City_____State_____Zip_____

Phone_____Email_____

If under 18, individual responsible for your account_____

Emergency Contact & Phone_____

How did you hear about me? _____

Have you had acupuncture before? Yes No

Have you been vaccinated for COVD-19: Yes No Vaccination Date/s? _____

Health Information

What are the health concerns for which you are seeking treatment? _____

_____

_____

How long have you had this condition? _____

What other forms of treatment have you sought?

_____

_____

What helps your condition? _____

What aggravates your condition? _____

Symptom Survey

For each symptom you currently have or have experienced recently, please rate the severity from 1-3 (3 being most severe). Leave blank if not applicable.

LV/GB		KD/UB		LU/LI	
	Irritability		Urinary problems		Catch colds easily
	Depression		Frequent urination		Nasal discharge
	Headache/migraine		Incontinence		Chronic stuffy nose
	Visual problems		Weakness/pain in lower back		Cough (wet/dry)
	Red eyes		Aching bones		Nose bleeds
	Dry/itchy eyes		Feeling cold		Itchy, red, painful throat
	Spots in field of vision		Low sexual energy		Dry mouth
	Blurred vision		Excess sexual energy		Skin rashes
	Feeling a lump in throat		Poor memory		Itchy skin
	Clenching/grinding teeth		Loss of hair		Acne
	Muscle cramping		Hearing problems		Other skin conditions
	Muscle twitching		Ringing in ears		Colitis/diverticulitis
	Stiff/tight joints		Dental problems		Constipation/diarrhea
	Cold hands/feet		Night sweats		Shortness of breath
	Brittle/soft nails		Fearful		Allergies
	Craving/avoiding sour foods		Craving/avoiding salty foods		Craving/avoiding spicy foods

SP/ST		HT/SI	
	Heaviness anywhere in the body		Heart palpitations
	Fatigue		Chest pain
	Edema		Dizziness
	Muscles often feel tired		Poor memory
	Easy bruising/bleeding		Anxiety
	Bad breath		Insomnia
	Low appetite		Easily startled, unable to relax
	Very high appetite		Restless, agitated
	Tendency toward hypoglycemia		Vivid and/or bothersome dreams
	Nausea		Get chilled often
	Vomiting		Lack of joy in life
	Gas/belching		Cold sweats
	Indigestion/heartburn		Mouth/tongue ulcers
	Bloating		Unable to make decisions
	Craving/avoiding sweet foods		Craving/avoiding bitter foods
	Over-thinking/worry		Burnt taste in mouth
	Irritable or light-headed with delayed meals		Nervous or “sour” stomach

Women Only

Please check all that apply

	Childbirth		Menses scanty or missed
	How many children?		Vaginal birth or C-section?
	Miscarriage		Painful menstruation
	Abortion		Blood clots
	Approximate date of menarche		Fibroids
	Cycle duration		Depression or mood change before cycle
	Length of menses		Acne worse with cycle
	Excessive and prolonged menses		Hot flashes or night sweats
	Menstruate too frequently		Hysterectomy
	Birth control	Date of last menstrual period:	
	Menopausal symptoms:		

Men Only

Please check all that apply

	Prostate trouble
	Urination difficult or dribbling
	Frequent urination at night
	Depression
	Lack of energy
	Feeling of incomplete bowel evacuation

Medications and Illnesses

Please list any prescriptions, over-the-counter medications, or supplements you are presently taking, including any you may only use occasionally

Medication/Supplement (and dosage):

_____

_____

_____

_____

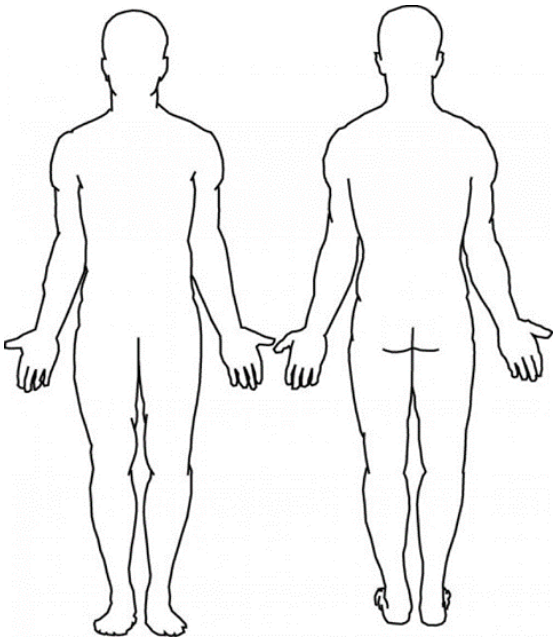
_____

_____

General Health History

	Alcoholism/drug addiction		Allergies/asthma
	Cancer		Diabetes
	Epilepsy		Heart disease
	Hypertension		Kidney disease
	Mental illness		Stroke
	Tuberculosis		Severe allergic reaction to medication/allergen
	Tobacco use		Caffeine (how often?)
	Dietary restrictions		Alcohol (how often?)

For patients with pain, please indicate on the figures below the areas of the body where you experience pain. How would you describe the quality of pain? _____



Please list any major surgeries, illnesses, or traumas and the year the event occurred:

_____

_____

_____

Insurance Information

If you are unable to verify your acupuncture benefits prior to your initial visit, please email this completed form OR a copy of your insurance card to jsprague@revolution-acupuncture.com before your first appointment.

Primary Policy

*Name of Insurance company_____*ID #_____

*Patient Name_____*Date of Birth_____

Name & Date of Birth of Primary Insured (if different than patient)_____

*Phone number for customer service_____

Claims Address_____

If Known:

Deductible _____Co-pay/Co-insurance _____Visit limits _____ Pre-auth required? _____

AUTHORIZATION OF RELEASE: I hereby authorize the release of any information acquired during the course of my examination and treatment to my insurance company.

Printed Name_____Date_____

X _____