Acupuncture Intake Form

PATIENT INFORMATION

Full name: _____ Date of birth: _____ dd / mm / yyyy

Phone number: _____ Email address: _____

Patient identifier (if known): _____ Gender: _____

ADDRESS

City: _____ State: _____

ZIP code: _____

REASON FOR SEEKING ACUPUNCTURE CARE

Specify below:

SPECIFIC CONCERNS OR SYMPTOMS

Specify below:

EMERGENCY CONTACT INFORMATION

Name: _____ Phone number: _____

Email: _____ Name: _____

Phone number: _____ Email: _____

HEALTH HISTORY

Do you have any past or current medical conditions?

◯ Yes ◯ No

If yes, please specify:

Are you currently taking any medications?

◯ Yes ◯ No

If yes, please list:

Have you undergone any surgeries?

◯ Yes ◯ No

If yes, please list:

Have you had acupuncture treatment before?

◯ Yes ◯ No

If yes, what was your experience?

Where is your pain located?

Indicate the type of pain you are facing:

- ☐ Sharp
- ☐ Piercing
- ☐ Aching
- ☐ Numbness
- ☐ Dull
- ☐ Shooting
- ☐ Tingling
- ☐ Stabbing

INSURANCE DETAILS

Insurance provider: _____ **Policy number:** _____

Rate your current pain on a scale from 1 (least) to 5 (worst):

◯ ◯ ◯ ◯ ◯

1 2 3 4 5

By signing below, I confirm that the information provided is accurate to the best of my knowledge.

Signature:

Date: _____ dd / mm / yyyy