Acupuncture - New Patient Intake Form

General Information

Name:_____ Date of Birth:_____ Age:_____

Address:_____

City:_____State:_____ Zip:_____

Phone: (primary)_____(secondary)_____

Email Address*:_____

**Would you like to receive emails regarding general studio updates? ____Yes ____ No*

Gender:_____ Height:_____ Weight:_____Occupation:_____

Employer:_____

How did you hear about us? _____

Who is your primary health care provider/MD?_____

Emergency Contact:_____Phone:_____

CANCELLATION POLICY

We honor and respect your time and our service to you is our highest priority. In return, we ask that you also respect our schedule so that we may be available not only to service you, but to also service others. InsideOut Body Therapies has a 24-hour cancellation policy for all scheduled appointments. There will be a charge of $50 for each instance a patient does not show for a scheduled appointment or does not give at least 24-hour cancellation notice. Payment will be required before or at the time of your next scheduled appointment. Thank you for your understanding of this policy, as this helps us to serve you and our other clients more promptly and efficiently. Please Initial and Date _____

Current Medical History

Reason for Visit/Health Concerns_____

_____

Does anything help with this issue?_____

What makes this issue worse?_____

What else have you tried to heal this issue?_____

On a scale of 1-10 (10 being the worst) how much does this issue affect your life?_____

List of medications_____

_____

List of vitamins and supplements_____
_____

Please list previous surgeries_____
_____

Do you have a pacemaker?_____ Do you have any metal plates, screws, or rods?_____

What are your main causes of stress?_____
_____

Rate your overall stress level: Low Medium High

What do you do to relax?_____
_____

What are your challenging emotions? (circle all that apply) Anger Frustration
Envy Depression Grief Worry Fear Apathy Jealousy
Annoyance Boredom Trust Shame Pity

Who do you live with?_____

Do you exercise? If so, what type and how often._____
_____

Are you on a diet? Or have any food restrictions?_____
_____

What kinds of foods do you eat that contain sugar?_____
_____

Do you smoke?_____ If yes, how much_____

What is your alcohol intake like? _____

Do you use recreational drugs?_____

What is your caffeine intake like?_____

How much water do you drink a day?_____

Do you have any allergies?_____ If yes, please ellaborate_____
_____

Is there anything else you think is important for me to know?_____
_____

Past Medical History

Please indicate any conditions you have now, you have had in the past, or you think might be important.

___AIDS/HIV
___Addiction
___Allergies
___Arteriosclerosis
___Asthma
___Autoimmune disease
___Birth trauma (yours)
___Cancer:_____
___Childhood illness
___Kidney or Gallstones
___Mental illness
___Migraines
___Multiple Sclerosis
___Pleurisy
___Pneumonia
___PTSD
___Rheumatic fever
___Seizures
___Diabetes
___Emphysema
___Epilepsy
___Goiter
___Gout
___Heart Disease
___Hepatitis
___Herpes
___High Blood Pressure
___Sexual/Physical/Emotional Abuse or Rape
___Sexually transmitted infection
___Stroke
___Tick-related disease
___Thyroid disease
___Trauma (fall, car accident):_____
___Tuberculosis
___Ulcers/GERD/Acid Reflux

Is there anything else I should know about your medical history?_____
_____
_____

Family Medical History

___Allergies/Autoimmune
___Arteriosclerosis
___Asthma
___Addiction
___Cancer:_____
___Diabetes
___Epilepsy/Seizures
___Headaches/Migraines
___Heart attack/Disease
___High Blood Pressure
___Mental illness
___Neurological (Dementia, Parkinson's, MS, etc.)
___Obesity
___Skin problems
___Stroke

Is there anything else I should know about your family's medical history?_____
_____
_____

InsideOut
BODY THERAPIES