Addison Acupuncture

Amber Addison L.Ac., Dipl.Ac. (NCCAOM)
1211 Laurens Rd, Suite D, Greenville SC 29607 Ph: (828) 275-1008

Acupuncture Intake Form

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information:

Name:_____ Age:_____ Today's Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone: _____ Email:_____
DOB:_____ If under 18, person responsible for your account: _____
Emergency Contact:_____ Contact Phone:_____
How did you hear about us? _____
Have you had acupuncture therapy before? YES NO With Whom? _____

Please indicate if any of the following pertain to you (marking "yes" does not make you ineligible for treatment; however, it may restrict some of our treatment modalities):

Hepatitis HIV High Blood Pressure Seizures Pacemaker Blood-thinning Meds Pregnancy

Please indicate the use and frequency of the following:

Coffee_____ Soda_____ Water_____
Alcohol_____ Rec. Drugs_____ Tobacco_____

Please list any prescriptions, herbs, over the counter medications you are presently taking:

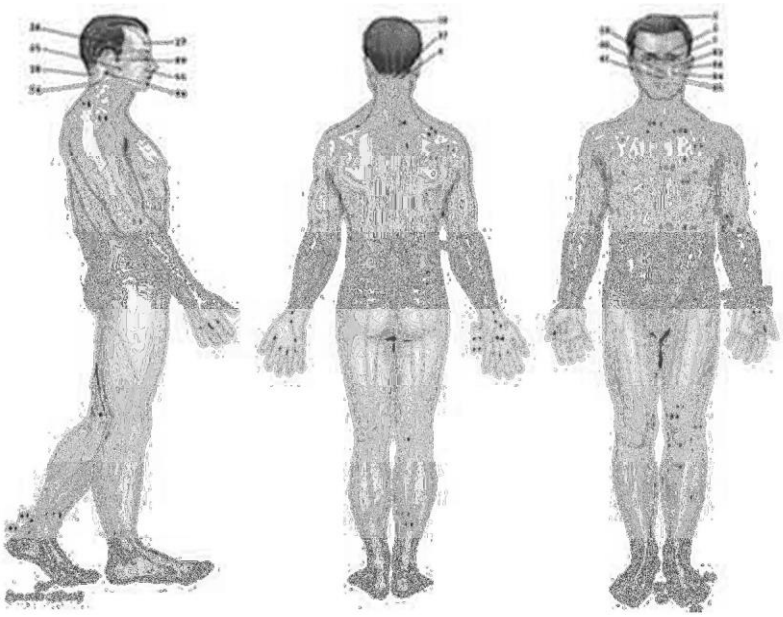
Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health History

What are the health concern(s) for which you are seeking treatment? _____
_____
_____
How long have you had this condition? _____
What other forms of treatment have you sought? _____
_____
What aggravates your condition? _____
_____
Please list any surgeries or major health incidents (accidents, etc.) in your life: _____
_____

Continued on back page

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain?

Dull/Achy Sharp/Stabbing Burning Tingling Numbness Electrical

Symptom Survey

Please check the symptoms or conditions you experience frequently.

Sp/St	Ht/P	Lu/Li	Ki/UB	Liv/GB
☐ Excessive appertite	☐ Insomnia	☐ Cough	☐ Low back pain	☐ Eye problems
☐ Loose stool/diarrhea	☐ Palpitations	☐ Shortness of breath	☐ Knee problems	☐ Jaundice
☐ Digestive problems, indigestion	☐ Cold hands/feet	☐ Decreased sense of smell	☐ Hearing impairment	☐ Difficulty digesting oily foods
☐ Vomiting	☐ Nightmares	☐ Nasal problems	☐ Ear ringing	☐ Gall stones
☐ Belching/burping	☐ Laughing for no reason	☐ Skin problems	☐ Kidney stones	☐ Light colored stool
☐ Claustrophobia	☐ Decreased sex drive	☐ Soft/brittle nails	☐ Easily angered	☐ Heartburn/reflux
☐ Stomach bloating	☐ Chest pains	☐ Colitis/diverticulitis	☐ Obsession in work, relationships, etc.	☐ Poor memory
☐ Constipation	☐ Hair loss	☐ Difficulty making decisions	☐ sadness	☐ Blood in stool
☐ Urinary problems	☐ Lack of appetite	☐ Hemorrhoids	☐ Easily bruised	☐ High cholesterol
☐ Recent use of antibiotics	☐ Dental problems	☐ Bitter taste		

Fatigue Edema Asthma Allergies Dizziness Get sick easily Headaches I usually feel warm I usually feel chilled

For Women Only:

Age of first period_____ Date of last period_____ Number of children (live births)_____ Number of days between periods (your cycle)_____ Number of days of flow_____

Color of flow: pale/light red red bright red dark red dark red/brown clots

Amount of flow: spotting light even throughout heavy
# of pads you use per day? 1st day____ 2nd day____ 3rd day____ 4th day_____ + days____

Pain and cramping: NO YES: __Before flow __During flow __After flow __Mild __Moderate__Severe
Other symptoms related to menses: Discharge PMS Headache Nausea Constipation Diarhhea Swollen breasts Mood swings Increased appetite Decreased appetite Insomnia
Have you ever been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian cysts PID Polycystic ovary syndrome STD_____