HealthFit

Acupuncture Intake Form

Date_____

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask.

Name_____ Name you prefer to be called: _____

Date of Birth_____ Age_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Intersex Preferred gender pronoun if not same as birth gender: _____

Height_____ Weight_____ Occupation_____

Have you been treated by Acupuncture or Chinese Medicine in the past? ☐ Yes ☐ No

Have you ever used herbal supplements before? ☐ Yes ☐ No

Have you ever used essential oils before? ☐ Yes ☐ No

What is/are the main problem(s) you would like help with? _____
_____

How long ago did this problem begin?_____

To what extent does this problem interfere with your daily activities? _____
_____

Have you been given a diagnosis for this problem? If so, what? By whom?_____
_____

What kinds of treatment have you tried?_____

_____

Are you on antibiotics now or have you used antibiotics in the past 3 months? If so, which antibiotics have you taken?
_____

Are you currently pregnant?_____ What is your due date?_____

Are you a Vegan? ☐ Yes ☐ No For how long? _____
Are you a Vegetarian? ☐ Yes ☐ No For how long? _____

Any additional information you would like to share with your acupuncturist _____

_____

_____

Patient Signature_____ Guardian Signature_____