Acupuncture Intake Form

Client Information

First Name	Last Name	Date of Birth	Patient Identifier (If known)
Lisa	Smith	23/03/1996	
Gender	**Preferred Pronouns**	**Email**	**Preferred Phone Number**
Female	She/her	lisas@gmail.com	000 0000

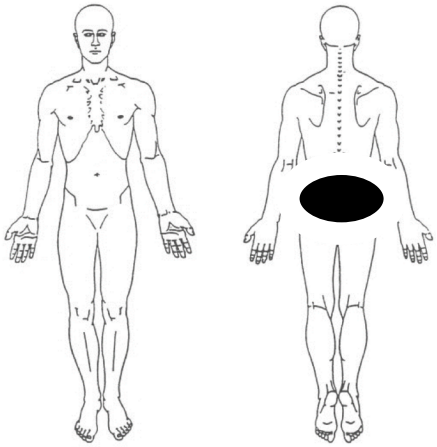
Address	City	State	Zip Code
123 Flower St, Gardenia Bay	Seattle	WA	0948

Emergency Contact

Full Name	Relationship	Contact Number
Anthony Smith	Father	948 949382
Jeremy Smith	Brother	0948 04938

Health Information

Spasm
Inflammation
Trigger Point
Elevation
Adhesion
Rotation
Pain
Tender Joint
Hypertonicity



Client Concerns

Tender lower back, due to strain from moving furniture

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

☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5

Indicate the type of pain you are facing

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

☐ Other, Please Specify: _____

Current Medical Conditions	Past Medical Concerns
Diabetes	N/a
Relevant Family History	**Current Injuries**
Mother has arthritis in knees	Lower back strain
Past Injuries	**Allergies**
N/a	N/a

Signature	Date
	10.01.2023