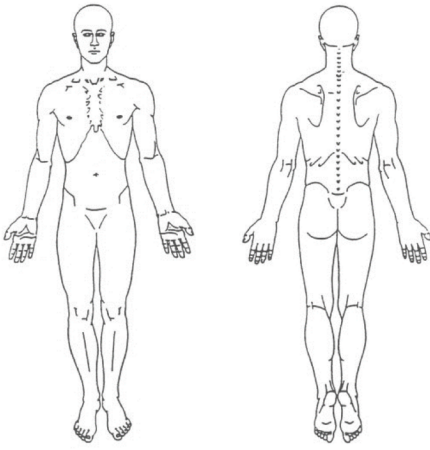


Acupuncture Intake Form

Client Information			
First Name	Last Name	Date of Birth	Patient Identifier (If known)
Gender	Preferred Pronouns	Email	Preferred Phone Number
Address		City	State
			Zip Code
Emergency Contact			
Full Name		Relationship	Contact Number
Full Name		Relationship	Contact Number
Health Information			
<div style="display: flex; align-items: flex-start;"> <div style="margin-right: 20px;"> <p>≡ Spasm</p> <p>○ Inflammation</p> <p>9 Trigger Point</p> <p>/ Elevation</p> <p>X Adhesion</p> <p>↻ Rotation</p> <p>○ Pain</p> <p>● Tender Joint</p> <p>≡ Hypertonicity</p> </div> <div style="text-align: center;">  </div> </div>		<p>Client Concerns</p> 	
<p>Rate your current pain on a scale from 1 (least) to 5 (worst)</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p>			
<p>Indicate the type of pain you are facing</p> <p><input type="checkbox"/> Sharp <input type="checkbox"/> Piercing <input type="checkbox"/> Aching <input type="checkbox"/> Numbness <input type="checkbox"/> Dull <input type="checkbox"/> Shooting <input type="checkbox"/> Tingling <input type="checkbox"/> Stabbing</p> <p><input type="checkbox"/> Other, Please Specify: _____</p>			
Current Medical Conditions		Past Medical Concerns	
Relevant Family History		Current Injuries	
Past Injuries		Allergies	
Signature		Date	