Acupuncture Intake Form

Patient information		
Full name:	Date of birth:	
Phone number:	Email address:	
Patient identifier (If known):	Gender:	
Address		
City:	State:	ZIP code:
Reason for seeking acupuncture care:		
Specific concerns or symptoms:		
Emergency contact information		
Name:	Phone number:	
Email:		
Name:	Phone number:	
Email:		
Health history		
Do you have any past or current medical conditions? ◯ Yes ◯ No		
If yes, please specify:		
Are you currently taking any medications? ◯ Yes ◯ No		
If yes, please list:		

Have you undergone any surgeries? ◯ Yes ◯ No

If yes, please list:

Have you had acupuncture treatment before? ◯ Yes ◯ No

If yes, what was your experience?

Where is your pain located?

Indicate the type of pain you are facing:

- ☐ Sharp
- ☐ Piercing
- ☐ Aching
- ☐ Numbness
- ☐ Dull
- ☐ Shooting
- ☐ Tingling
- ☐ Stabbing
- ☐ Other, please specify:

Insurance details

Insurance provider:	Policy number:

Rate your current pain on a scale from 1 (least) to 5 (worst): ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

By signing below, I confirm that the information provided is accurate to the best of my knowledge.

Signature:

Date: