Silk & Soul Acupuncture, LLC

Health Intake Questionnaire

Please complete this questionnaire as thoroughly as possible and return via email prior to your first visit or print it and bring it with you. All answers are confidential.

Date _____

Name _____

Address _____
City_____ State _____ Zip _____

Phone: Cell _____ Home _____ Work _____

Date of Birth _____ Age _____ Email_____

Gender _____ Marital Status _____ Height _____ Weight _____

Spouse/Partner(s) _____
Children & ages _____

Pets_____

Education _____

Occupation _____ Employer _____

Emergency Contact _____ Relation _____
Emergency Contact phone _____

*Name of physician _____ Phone _____
*Name/type of specialist _____ Phone _____

*No contact will be made without your permission.

Reason(s) for seeking acupuncture
_____

Past Medical History

Surgeries (please include dates if available):

_____

_____

Hospitalization (please include dates if available):

_____

_____

Major Illnesses (please include dates if available):

_____

_____

Family Medical History

	Age	Alive	Deceased	Health History
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Spouse	_____	_____	_____	_____
Child	_____	_____	_____	_____
Child	_____	_____	_____	_____

Lifestyle Habits

Cigarettes (packs per day/wk) _____ Started (yr) _____ Quit (yr) _____
Alcohol (drinks per day/week/month) _____ Wine/beer/liquor _____
Coffee/Tea (cups per day) _____ Soda (regular/diet per day) _____
Recreational drug use/frequency _____
Exercise/type/frequency _____

Medicines

Medication _____ Dose _____
Medication _____ Dose _____
Medication _____ Dose _____
Vitamins _____ Dose _____
Vitamins _____ Dose _____
Vitamins _____ Dose _____

Supplement _____ Dose _____
Supplement _____ Dose _____

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS
If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experienced the condition both in the past and currently.

General
____ Insomnia ____ Dreams/ nightmares ____ Fatigue ____ Poor memory ____
Strongly like cold drinks ____ Strongly like hot drinks ____ Cold hands & feet ____
Chills ____ Fever ____ Bad breath ____ Recent weight loss/gain
Other (describe) _____

Head & Neck
____ Headaches ____ Migraines ____ Stiff neck ____ Dizziness ____ Fainting
____ Swollen glands Other (describe) _____

Ears
____ Ringing ____ Hearing loss ____ Hearing aids ____ Infections ____ Earache ____
Vertigo Other (describe) _____

Eyes
____ Glasses/ contact lenses ____ Blurred vision ____ Poor night vision
____ Spots/floaters ____ Eye inflammation ____ Double vision ____ Glaucoma ____
Cataracts ____ "Lazy" eye
Other (describe) _____ How often checked? _____

Nose, Throat & Mouth
____ Sinus infection ____ Hay fever/ allergies ____ Frequent sore throat ____
Difficulty swallowing ____ Mouth & tongue ulcers ____ Frequent colds ____
Nosebleed ____ Dry nose ____ Nasal congestion ____ Loss of voice ____ Thirst
____ Excessive phlegm ____ TMJ ____ Facial pain ____ Gum problems ____ Dry mouth
Other (describe) _____
____ Dental problems? Last visit _____

Skin
____ Hives ____ Rashes ____ Eczema/ psoriasis ____ Night sweating
____ Excess sweating ____ Dry skin ____ Easily bruised ____ Itching
____Changes in moles, lumps Other (describe) _____

Respiratory
____Difficulty breathing ____ Difficulty breathing when reclining ____ Wheezing ____
Asthma ____ Chronic cough ____ Wet cough ____ Dry cough
____ Coughing up phlegm ____Coughing up blood ____ Shortness of breath
____ Tight chest ____ Pneumonia Other (describe) _____

Cardiovascular
____ High blood pressure ____ Low blood pressure ____ Chest pain or tightness
____ Palpitation ____ Rapid heart beat ____ Irregular heart beat ____ Poor circulation
____ Swollen ankles. ____ Phlebitis ____ Anemia ____ History of heart disease
____ Heart murmur ____ Night sweats ____ Tendency to be cold/warm Other (describe) _____

Gastrointestinal
____ Nausea ____ Indigestion ____ Stomach pain ____ Diarrhea ____ Constipation ____ Poor appetite ____ Excessive hunger ____Vomiting ____ Gas ____ Hiccups ____ Acid regurgitation ____ Bloating ____ Laxative use ____ Bloody stool
Number of bowel movements/day _____ Other (describe) _____

Musculoskeletal
____ Joint pain/swelling ____ Sore muscles ____Weak muscles
____ Pain/Difficulty walking (please describe)_____
____Limited range of motion Other (describe) _____

Neurological
____ Seizures ____ Tremors ____ Numbness or tingling ____ Paralysis
____ Poor coordination _____Pain (describe) _____
Other (describe) _____

Urinary
____ Pain on urination ____ Frequent urination ____ Urgent urination
____ Blood in urine ____ Incontinence ____ Incomplete urination ____ Bedwetting
____ Wake to urinate ____ History of UTI ____
Kidney (specify) _____ Other (describe) _____

Reproductive/Sexual Health
____ Currently pregnant ____ # of Pregnancies ____ # of Live births
____ # of Miscarriages ____ # of Abortions ____ Menopause ____ Irregular periods
____ Menstrual cramps (Intensity 0-10: _____) ____ Excessive blood low
____ Menstrual blood clots ____ Breast tenderness ____ Abnormal pap smear
____ Vaginal infections ____ Vaginal pain/itching ____Uterine fibroids
____ Endometriosis ____ Breast lumps, cysts ____ Increased/Decreased libido
____ Pain/itching of genitalia ____ Difficulty achieving orgasm
____ Breast checked (date of last exam)
____ Impotence ____ Premature ejaculation ____ Nocturnal emission
____ Lumps in testicles Other (describe) _____

Mental/Emotional
____ Depression ____ Mood swings ____ Irritability ____Difficulty relaxing
____ Loneliness ____ Sensitive ____ Shyness ____ Frequent crying
____ Compulsive behaviors ____Worries frequently ____Difficulty focusing

____ Hopeless outlook ____ Suicidal thoughts ____ Lose temper ____ Frustration
Other (describe) _____

Infection Screening (circle self and/or partner)
____ HIV risks: self or partner
____ TB: self or household
____ Hepatitis risk: self or partner
____ History of sexually transmitted disease - self or partner (specify)
_____
Other (describe) _____

Trauma(s) _____

Allergies_____

Other pertinent information
_____
_____
_____

_____ Patient Signature _____ Date

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Acupuncture Fees: Intake/Traditional Diagnosis - $125.00; Follow-up Treatments $85.00

The following fees apply: Late Cancellation/No Show $25.00 Return Check Fee $35.00

We accept cash, personal checks credit cards (Mastercard and Visa), FSA and HSA debit cards, and CashApp. Kindly make all checks payable to Silk & Soul Acupuncture, LLC.

Thank you!