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:	