Acupuncture Center for Balance & Healing

560 Davidson Gateway Drive· Suite 200· Davidson NC· 28036

www.AcuCenterBH.com · Tel: 704.896.0217

New Client Intake Form

Personal Information

Name ____________________ Date ____________________

Address ____________________ City ____________________

State __________ Zip __________ Home Phone ____________________

Email ____________________ Cell Phone ____________________

Date of Birth __________ Age __________ Martial Status ____________________

Occupation ____________________ Business Phone ____________________

# of Children __________ Ages of Children ____________________

Emergency Contact ____________________ Phone ____________________

Reason For Visit ____________________ Referred by? ____________________

How long have you had this condition? ____________________

What seems to make it better? ____________________ Worse? ____________________

Are you currently under the care of a physician? ____________________

Physicians Name ____________________ Phone ____________________

Family Medical History

___ Alcoholism ___ Cancer ___ Depression ___ Diabetes

___ High Blood Pressure ___ Heart Disease ___ Seizures ___ Stroke

Your Past Medical History (Check any of the following conditions you currently have, or have had in the past.)

___ AIDS/HIV	___ Epilepsy	___ Pacemaker	___ Venereal Disease
___ Alcoholism	___ Heart Disease	___ Seizures	___ Other (PLEASE EXPLAIN)
___ Allergies	___ Hepatitis Type ______	___ Stroke	____________________
___ Birth Trauma	___ Herpes Type ______	___ Surgeries please list	____________________
___ Cancer	___ High Blood Pressure	___ Thyroid Disorders	____________________
___ Diabetes	___ Multiple Sclerosis	___ Ulcers	

Your Diet

Appetite: High ____ Low ____ Which foods do you crave? ____________________

Do you suspect any allergies or sensitivities to certain foods? If so, Explain ____________________

____

____

Do you use artificial sweetener? ____________________ What drinks do you prefer? Hot ______ or Cold ______

Do you drink coffee/tea? __________ How many cups per day? ____ Regular or Decaf? ____________________

Vitamins or Supplements you take on a daily basis? ____________________

____

Pharmaceuticals? ____________________

____

New Client Intake Form Continued

Your Lifestyle

Do you drink alcohol?____________ How many drinks per week? ____

Do you smoke? ____________Have you smoked in the past? ______________How many per week? ______________________

Do you use recreational drugs or abuse prescription drugs?____________ How Long?________________________________

Please explain ____

Do you lead a stressful lifestyle?_____ Occupational Hazards?________ Do you Exercise?________ How Often?__________

General Symptoms (Check any of the following conditions you currently have, or have had in the past.)

___ Poor Sleep	___ Red Eyes	___ Nausea	___ Poor Memory
___ Trouble Falling Asleep	___ Dry Eyes	___ Vomiting	___ Depression
___ Staying Asleep	___ Poor Vision	___ Gas	___ Anxiety
___ Dream- Disturbed Sleep	___ Grinding Teeth	___ Diarrhea	___ Irritability
___ Fatigue	___ Sores on Lips/Tongue	___ Constipation	___ Easily Stressed
___ Lack of Strength	___ Sinus Problems	___ Hemorrhoids	___ Abuse Survivor
___ Body Heaviness	___ Lumps in Throat	___ Intestinal Pain/ Cramping	___ Suicide Thoughts
Where? ____________	___ Nosebleeds	___ Bowel Movements	___ Seeing a Therapist
___ Cold Hands and Feet	___ Ringing in Ears	_______ x per day	___ Frequent Urination
___ Fever	___ Earaches	___ Rashes	___ Pain in Urination
___ Poor Circulation	___ Headaches	___ Eczema	___ Bedwetting
___ Shortness of breath	___ Tightness in Chest	___ Psoriasis	___ Increased Libido
___ Night Sweats	___ Cough	___ Acne	___ Decreased Libido
___ Spontaneous Sweating	___ Blood Clots	___ Pain or Weakness	___ Impotence
___ Muscle Cramps	___ Fainting	___ Hair Loss	___ Root Canal
___ Dizziness	___ Heart Palpitations	___ Fungal Infections	Which teeth? __________
___ Bleed or Bruise Easily	___ Irregular Heart Beat	___ Numbness	

Women Only

Date of last menstrual cycle ___________ Duration of flow __________ days Duration between cycles_________ days

Irregular Periods? ___ Painful Periods? ___ Clotting? _____ Heavy Flow?____ Light Flow? ___ Breast Tenderness? _______

PMS? _______ Cramping? _______ Bearing Down Sensation? ________ Vomiting/Diarrhea before Menstruation? _________

Any Fertility Issues? ___________ If yes, duration and please explain? ____

# of Pregnancies? ______________ # of Live Births? ______________ # of Miscarriages____________ When? _____________

Are you or could you be pregnant right now? _________________If yes, how many weeks? ____________________________

Age at menopause ____________ Do you experience hot flashes? _______________ How often? ________________________

Are there any other health conditions or issues you want to discuss? If so, please explain:

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To the best of my knowledge this information is true and accurate.

Signature____ Date ____

Parent or Guardian Signature_____________________________________ Date ____