abundant wellness acupuncture

PATIENT INTAKE FORM

Name _____ Phone _____

Address _____ City _____ State _____

Email Address _____ Occupation _____ Date _____

Age _____ Birthdate ____/____/____ Birth City/ State _____ Birth Time _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Physician _____ Phone _____

Other Medical Providers

_____ Title _____ Phone _____

_____ Title _____ Phone _____

Medications, Supplements, Vitamins, Herbs, Homeopathy, Laxatives & Reasoning for Taking.

_____ for _____ | _____ for _____

_____ for _____ | _____ for _____

_____ for _____ | _____ for _____

List Any Significant Surguries, Operations, Miscarriages, Accidents, Hospitalizations, Etc. & Month/Year.

_____

_____

_____

_____

What Brings You In? _____

_____ How long has this been going on _____

When Did It Start? _____ Conditions Getting: ☐ better ☐ worse ☐ same ☐ constant ☐ on&off

Happen More: ☐ morning ☐ afternoon ☐ night Symptoms are: ☐ sharp/stabbing ☐ dull/aching

What helps? _____ What makes worse? _____

On a scale from 0-10, 10 being the worst it is a _____/10 Have you ever had acupucnture ? _____

**Please mark any of the following conditions you may currently have that you are comfortable with sharing.

Musculoskeletal

- [ ] Pain | ____/10 (worst)

describe _____
_____

- [ ] Joint Pain
- [ ] Swelling
- [ ] Sore Muscles
- [ ] Weak Muscles
- [ ] Difficulty Walking
- [ ] Limited Range of Motion
- [ ] Numbness
- [ ] Tingling
- [ ] Other _____

_____

Cardiovascular

- [ ] High Blood Pressure
- [ ] Blackouts/Fainting
- [ ] Irregular Heartbeat
- [ ] Heart Valve Problem/MurMur
- [ ] Angina/Chest Pain
- [ ] Low Blood Pressure
- [ ] Hot Hands/Feet
- [ ] Cold Hands/Feet
- [ ] Rapid Heartbeat/palpitations
- [ ] Coronary Heart Disease
- [ ] Blood Clot
- [ ] Stroke
- [ ] Phlebitis
- [ ] Swelling of Hands Swelling of Feet
- [ ] Anemia
- [ ] Bruise Easily
- [ ] Varicose Veins Generally Hot
- [ ] Generally Cold
- [ ] High Cholesterol
- [ ] Other _____

_____

Sleep

Avg Hours of Sleep per Night? _____ hrs

- [ ] Difficulty Falling Asleep
- [ ] Difficulty Staying Asleep
- [ ] Difficulty Waking Up
- [ ] Dream Disturbed Sleep
- [ ] Nightmares
- [ ] Wake up Not Refreshed
- [ ] Awake at Night : Thinking
- [ ] Need to Take Naps
- [ ] Sleepy in Afternoon
- [ ] Shallow Sleep

Hair, Skin, & Nails

- [ ] Rashes
- [ ] Hives
- [ ] Itching
- [ ] Shingles
- [ ] Pimples/Acne
- [ ] Ulcerations/Sores
- [ ] Fungus on Skin
- [ ] Fungus Under Nails
- [ ] Eczema
- [ ] Boils
- [ ] Psoriasis
- [ ] Moist Feet/Hands
- [ ] Weak/Brittle Nails
- [ ] Recent Moles
- [ ] Easily Bruised
- [ ] Loss of Hair
- [ ] Warts
- [ ] Dandruff
- [ ] Itching
- [ ] Dry Skin
- [ ] Dry Hair

Eyes & Ears

- [ ] Sensitivity to Light
- [ ] Night Blindness
- [ ] Conjunctivitis
- [ ] Dry Eyes
- [ ] Nearsighted
- [ ] Itchy Eyes
- [ ] Watery Eyes Red Eyes
- [ ] Pressure Behind Eyes
- [ ] Blurred Vision
- [ ] Floating Spots
- [ ] Eye Pain
- [ ] Farsighted
- [ ] Cataracts
- [ ] Glaucoma
- [ ] Blindness
- [ ] Eyeglasses/Contacts
- [ ] “Lazy” Eye
- [ ] Ringing
- [ ] Deafness
- [ ] Difficulty Hearing
- [ ] Hearing Loss
- [ ] Hearing Aids
- [ ] Infections
- [ ] Earache
- [ ] Double Vision
- [ ] Ears Frequently Pop
- [ ] Vertigo

Stress

Stress Level 0-10 (10 worst) _____

- [ ] Feel Overwhelmed
- [ ] Feel Heavy
- [ ] Anxiety
- [ ] Can Handle Stress
- [ ] Can’t Handle Stress
- [ ] Panic Attacks
- [ ] Hard to Breath when Stressed

Respiratory

- [ ] Difficulty Breathing
  - [ ] When Reclining
- [ ] Coughing
  - [ ] Chronic
  - [ ] Wet
  - [ ] Dry
  - [ ] Up Phlegm
  - [ ] Up Blood
- [ ] Shortness of Breath
- [ ] Pneumonia
- [ ] Bronchitis
- [ ] Asthma
- [ ] Difficult to Inhale
- [ ] Difficult to Exhale
- [ ] Wheezing
- [ ] Tight Chest
- [ ] Other_____

_____

Women*

Pregnancies _____ Miscarriages _____
Menses (used to) last ____ days

- [ ] Had/Have Blood Clotting
- [ ] Cramping
  before | during | after
- [ ] Painful Ovulation
- [ ] Bleeding in Between Period
- [ ] Irregular
- [ ] Birth Control
- [ ] Painful Sex
- [ ] Low Libido
- [ ] High Libido
- [ ] Pre-Menopause
- [ ] Menopause
- [ ] Post Menopause
- [ ] Fibroids
- [ ] STD
- [ ] Breast Implants
- [ ] Other Surgery _____

_____

Gastrointestinal

Bowel Movements: _____ per day
Usually : Hard | Firm | Soft | Loose | Liquid

- [ ] Nausea
- [ ] Constipation
- [ ] Diarrhea
- [ ] Colitis
- [ ] Indigestion
- [ ] Abdominal Bloating
- [ ] Excessive Appetite
- [ ] Poor Appetite
- [ ] Hiccups
- [ ] Vomiting
- [ ] Parasites
- [ ] Ulcer
- [ ] Black Stool
- [ ] Upper/Lower Abdominal
- [ ] Pain/Cramping
- [ ] Bad Breath
- [ ] Gas Belching
- [ ] Loose Stools
- [ ] Laxative Use
- [ ] Bowel Movements Feel Incomplete
- [ ] Other _____

_____

Men*

- [ ] Irregular Prostate
- [ ] Vasectomy
- [ ] Low Libido
- [ ] High Libido
- [ ] Painful Sex
- [ ] Low Testosterone
- [ ] High Testosterone
- [ ] STD
- [ ] Other _____

_____

Family History

- [ ] Alcoholism
- [ ] Asthma
- [ ] High Blood Pressure Heart
- [ ] Disease Coronary Artery
- [ ] Disease
- [ ] HIV/AIDS
- [ ] Diabetes
- [ ] Seizures
- [ ] Allergies
- [ ] Cancer
- [ ] Thyroid Disorder Kidney
- [ ] Disorder Psychology/Mental
- [ ] Illness Liver Disease
- [ ] Stroke
- [ ] Lung Disease
- [ ] Arthritis
- [ ] Dementia
- [ ] Alzheimer's
- [ ] Blood Disorder
- [ ] Musculo-Skeletal Disorder
- [ ] Suicide

Payments

Cash,
Personal Check,
(Bridget Lanza)

PayPal,
(abundantwellnessacu@gmail.com)

& Zelle
(4439023716)

are all acceptable forms of payment.
Less than 24 hour notice, will be charged for full price of appointment
Thank you for understanding!

Signature _____