SKILLED Touch
HEALTH & HEALING

Acupuncture Intake

Thank you for taking the time to fill out this health packet. It will help Chelsea get a clear picture of your body as a whole. This is so that she can customize a treatment plan unique for you. All information provided is completely confidential.

General Information Today's Date:_____

Name:_____ Age:_____ Date of Birth:_____
First Middle Last
Address:_____
Street City State Zip Code
Phone #:_____ Email:_____

Sex:
___Male ___Female

Marital Status:
___Single ___Married ___Separated ___Divorced ___Widowed

Occupation:_____ How did you hear about us?_____

Emergency Contact:_____ Relationship:_____

Phone #:_____ Primary Care Physician:_____

Have you received Acupuncture before? ___Yes ___No

Do you feel safe at home? ___Yes ___No

Health Information

Primary Complain

_____

_____

Date of Onset:_____ Have you seen an M.D. about this?____ Diagnosis:_____

Therapies that you have tired:_____

Better with? Worse with?

_____ _____

_____ _____

Other Complaints

_____

_____

Medical History

Significant Traumas (Surgeries, Hospitalizations, Injuries, Loss of a Loved one, Divorce, etc.)

Date	Event

Medications and Supplements (Attach another sheet if needed)

Medication	Dosage	Reason	Date Started	Date Stopped

Family Health History

Family Member	Major diseases
Mother	
Father	
Sister(s)	
Brother(s)	
Mathernal Grandma	
Maternal Grandpa	
Paternal Grandma	
Paternal Grandpa	

Please Circle current symptoms and Underline symptoms you have experienced in the past

Abuse	Addiction	Anemia	Appendicitis	Arteriosclerosis
Asthma	Candida	Chronic Pain	Concussion	Bowel Disease
Diabetes	Digestive Disorder	Emphysema	Epilepsy/Seizures	Fatigue
Fibromyalgia	Gallstones	Goiter	Gout	Headaches
Heart Disease	Hemophilia	Hernia	Herpes	Hepatitis
HIV/AIDS	Hypertension	Hypotension	Hyperthyroid	Hypothyroid
Kidney Disease	Kidney Stones	Liver/Gallbladder Disease		Migraines
Mental/Emotional Imbalance		Meningitis	Mononucleosis	Multiple Sclerosis
Organ Prolapse	Pacemaker	Pneumonia	PTSD	Neuralgia
Prostate Disorder	Raynaud's Disease	Shunt	STD	Stent
Stroke/CVA	Tuberculosis	Ulcers	Urinary Disorders	

Cancer_____

Allergies

_____

_____

Life Style

Alcohol use
Frequency_____ Amount per use_____

Tobacco use
Type_____ Start Date_____ Frequency of use_____

Recreational Drug use: Yes or No

Exercise
Days/Week_____ Duration_____ Type_____

Stress Level
Low 1 2 3 4 5 6 7 8 9 10 High

Energy
Low 1 2 3 4 5 6 7 8 9 10 High

Diet

Sample of a day's intake

Breakfast:_____

Lunch:_____

Supper:_____

Snacks:_____

Drinks:_____

Dietary Restrictions:_____

How would you rate your diet?

Poor 1 2 3 4 5 6 7 8 9 10 Healthy

Women's Health

Date of last period:_____ Date of last PAP:_____

If pregnant, how far along?_____ Breastfeeding? If so, how long?_____

Age menses started:____ # of pregnancies:_____ # of live births:____

#of miscarriages:____ #of abortions:____ # of premature births:____

Length of whole menstrual cycle:_____ Days of bleeding:_____

Color of blood (pale red, bright red, purple, dark red)_____

Amount of blood?_____ Clots?_____

How many times per day do you change your product?_____

PMS symptoms:_____

Are you sexually active?_____ Do you practice safe sex?____ Birth control method?_____

Please Circle current symptoms and Underline symptoms you have experienced in the past

Irregular Cycle	Bleeding between periods	Pain during intercourse
Painful Menses	Irregular discharge	Vaginal itching/burning
Vaginal odor	Vaginal dryness	Endometriosis
PCOS	Uterine Fibroids	Pelvic surgery
Ovarian Cysts	Breast pain	Nipple discharge
Breast lumps	Infertility	
Other_____		

Men's Health

Please Circle current symptoms and Underline symptoms you have experienced in the past

Testicular masses	Testicular pain	Premature ejaculation
Seminal emission	Discharge or sores	Impotence
Pain associated with genitals		
Other_____		

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