



Acupuncture Intake

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

\_\_\_\_ Male \_\_\_\_ Female SS# \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by \_\_\_\_\_ Physician \_\_\_\_\_

Primary Health Problems: \_\_\_\_\_

Reason for seeking Acupuncture Treatment: \_\_\_\_\_

Have you had any of the following (please give dates):

Have you had acupuncture before? \_\_\_\_\_

Name of acupuncturist \_\_\_\_\_

Hepatitis \_\_\_\_\_ Herpes \_\_\_\_\_ T.B. \_\_\_\_\_ HIV \_\_\_\_\_

Chronic or serious illness: \_\_\_\_\_

Severe Contagious disease: \_\_\_\_\_

Surgery: \_\_\_\_\_

Accidents or severe physical trauma: \_\_\_\_\_

Psychological or emotional trauma: \_\_\_\_\_

Please list all medications you are currently taking \_\_\_\_\_

Please list all vitamins and/or supplements that you are taking: \_\_\_\_\_

Comments or further information: \_\_\_\_\_

Name and telephone number of your doctor: \_\_\_\_\_

As a registered acupuncturist, I am required by Pennsylvania state law to have a script from a physician. An acupuncturist is responsible solely for the acupuncture evaluation and treatment. The medical diagnosis is the responsibility of the acupuncturist's supervisor. The acupuncturist will promptly consult with the supervisor regarding a new illness/condition, or worsened illness or condition of the patient.

Patient sign here: \_\_\_\_\_ Date: \_\_\_\_\_