HOSTA LANE
ACUPUNCTURE

# Patient Information Intake Form

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|---|---|---|---|
| Date: | | | |
| Name: | | | |
| Address: | | | |
| Phone: | | | |
| Email: | | | |
| Emergency Contact Name: Phone:<br>Relationship: | | | |
| Age: | Birthday: | Height: | Weight: |
| Gender: | Preferred Pronoun: | | |
| Occupation: | | | |

| |
|---|
| Have you discussed with your physician about receiving acupuncture treatment?<br>Yes ☐ No ☐ Name of physician: |
| Are You Pregnant? ☐Yes ☐No Planning to get pregnant? ☐Yes ☐No |

Check if applicable:

| | | |
|---|---|---|
| ☐ Pacemaker | ☐ Skin infection | ☐ Cancer |
| ☐ Medication pump | ☐ Bleeding disorder | ☐ Cortisone Injections |

| | |
|---|---|
| Do you have a contagious disease at this time? | Yes☐ No ☐ |
| Allergies: ☐ Yes ☐ No Please List: | |

Please list any medications or supplements that you are taking:

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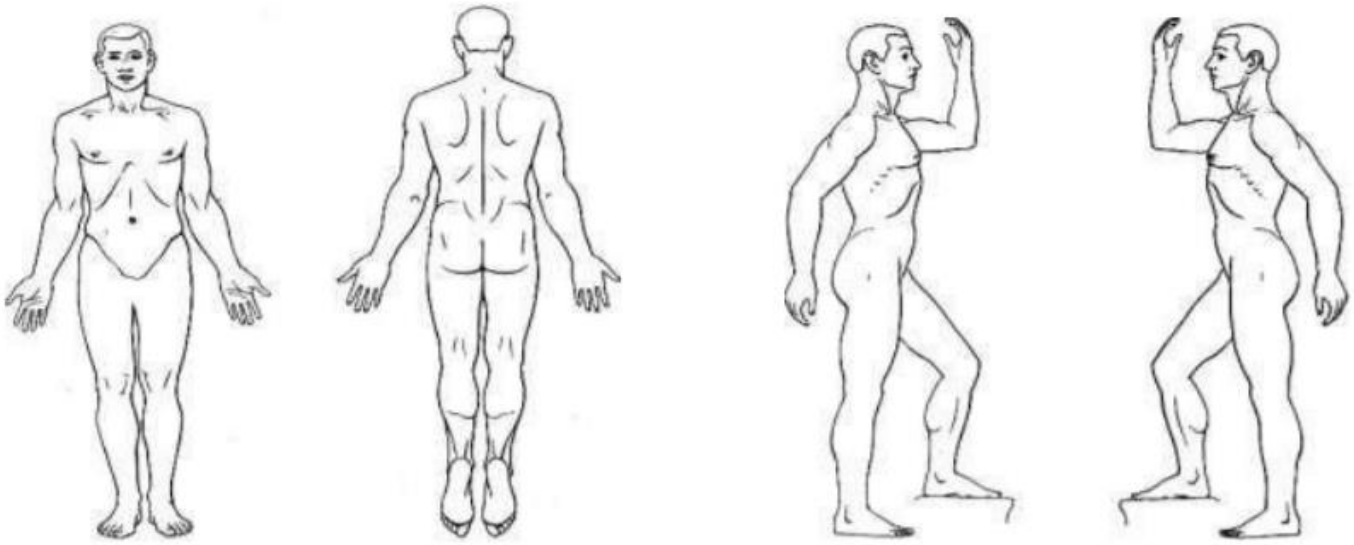
|---|
| |
| Have you ever had surgery or have been hospitalized? ☐ No ☐ Yes describe below |
| |

Please check any boxes that are relevant to your health:

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Fibromyalgia | ☐ Glaucoma | ☐ Mental Health |
| ☐ Parkinson's | ☐ Chronic fatigue | ☐ Cataracts | ☐ Anxiety |
| ☐ Low Blood Pressure | ☐Nausea &/or Vomiting | ☐ Earaches | ☐ Depression |
| ☐ High Blood Pressure | ☐ Diarrhea | ☐ Dental problems | ☐ ADHD |
| ☐ Chest Pain/Angina | ☐ Constipation | ☐ Sores on tongue or lips | ☐ PTSD |
| ☐ Heart Attack | ☐ Irritable Bowel Syndrome | ☐ TMJ | ☐ Memory loss |
| ☐ Stroke or TIA | ☐ Bloating after meals | ☐ Bell's Palsy | ☐ Stress |
| ☐ Irregular Heart rate | ☐ Gas &/or Hiccups | ☐ Trigeminal neuralgia | ☐ Restless legs |
| ☐ Clotting disorders | ☐ Acid reflux | ☐ Swollen glands | ☐ Concussions |
| ☐ Asthma | ☐ Ulcers | ☐ Enlarged thyroid | ☐ Headaches |
| ☐ Productive Cough | ☐ Ulcerative Colitis | ☐ Hernia | ☐ Migraines |
| ☐ Sinus problems | ☐ Diverticulitis | ☐ Insomnia | ☐ Epilepsy |
| ☐ Nosebleeds | ☐ Hemorrhoids | ☐ Nightmares | ☐ Other |

Please indicate areas of pain or concern:



Describe your condition: