



Acupuncture for Southern Living

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Patient Intake Form

**Please fill in as much information as you can provide.**

Today's Date \_\_\_\_\_

PERSONAL INFORMATION

Name \_\_\_\_\_ S.S # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_

Phone # (W) \_\_\_\_\_ (H) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Name and phone number of the emergency contact person \_\_\_\_\_

Insurance company \_\_\_\_\_ Insured (if not yourself) \_\_\_\_\_

Date of birth of insured \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Primary physician's name, phone #, and address \_\_\_\_\_

Have you had acupuncture treatment before?

If yes, where and when \_\_\_\_\_

Are you seeking other health care professional's help for your current condition?

Y\_\_N\_\_

If yes, please list their names, specialties, phone #s, and addresses \_\_\_\_\_

PAST MEDICAL HISTORY

Please list all past medical conditions and hospitalizations.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY HEALTH HISTORY

Describe your mother's health briefly \_\_\_\_\_

Describe your father's health briefly \_\_\_\_\_

What illnesses are prominent in your family? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_

Are you taking any supplements or herbs? \_\_\_\_\_

## CURRENT HEALTH CONDITION

Please check all that apply to you.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> asthma                      | <input type="checkbox"/> fibromyalgia              | <input type="checkbox"/> lupus               |
| <input type="checkbox"/> allergies                   | <input type="checkbox"/> frequent urination        | <input type="checkbox"/> lyme's disease      |
| <input type="checkbox"/> anxiety                     | <input type="checkbox"/> feeling cold              | <input type="checkbox"/> menstrual disorders |
| <input type="checkbox"/> AIDS/HIV                    | <input type="checkbox"/> feeling hot               | <input type="checkbox"/> neck pain           |
| <input type="checkbox"/> arthritis                   | <input type="checkbox"/> foot pain                 | <input type="checkbox"/> numbness & tingling |
| <input type="checkbox"/> back pain                   | <input type="checkbox"/> gastrointestinal disorder | <input type="checkbox"/> night sweats        |
| <input type="checkbox"/> blurred vision              | <input type="checkbox"/> gout                      | <input type="checkbox"/> palpitation (heart) |
| <input type="checkbox"/> breathing difficulties      | <input type="checkbox"/> glaucoma                  | <input type="checkbox"/> poor appetite       |
| <input type="checkbox"/> cancer                      | <input type="checkbox"/> hepatitis                 | <input type="checkbox"/> poor coordination   |
| <input type="checkbox"/> carpal tunnel syndrome      | <input type="checkbox"/> hot flashes               | <input type="checkbox"/> persistent cough    |
| <input type="checkbox"/> chest pain (or tightness)   | <input type="checkbox"/> headache                  | <input type="checkbox"/> restlessness        |
| <input type="checkbox"/> chronic fatigue             | <input type="checkbox"/> heart problems            | <input type="checkbox"/> shoulder pain       |
| <input type="checkbox"/> constipation                | <input type="checkbox"/> hives                     | <input type="checkbox"/> spinal misalignment |
| <input type="checkbox"/> depression                  | <input type="checkbox"/> high blood pressure       | <input type="checkbox"/> spinal fusion       |
| <input type="checkbox"/> diabetes                    | <input type="checkbox"/> irritable bowel syndrome  | <input type="checkbox"/> skin problem        |
| <input type="checkbox"/> diarrhea                    | <input type="checkbox"/> immune deficiency         | <input type="checkbox"/> sport injury        |
| <input type="checkbox"/> difficult concentrating     | <input type="checkbox"/> itchiness                 | <input type="checkbox"/> sciatica            |
| <input type="checkbox"/> digestion problems          | <input type="checkbox"/> insomnia                  | <input type="checkbox"/> stress              |
| <input type="checkbox"/> dizziness/ light headedness | <input type="checkbox"/> lack of clarity           | <input type="checkbox"/> tendonitis          |
| <input type="checkbox"/> other (please specify)      |  |  |

Please describe in detail the health concern (s) you want us to help with

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## LIFE STYLE AND NUTRITION

Do you have a regular eating habit? Y\_\_N\_\_

Do you usually feel hurried for your meals? Y\_\_N\_\_

Do you snack? Y\_\_N\_\_

Do you crave for certain taste or foods? Y\_\_N\_\_

If yes, what do you crave for? \_\_\_\_\_

Are you a vegetarian? Y\_\_N\_\_

If yes, do you eat eggs? Y\_\_N\_\_

Which of the following do you consume regularly?

Caffeine \_\_\_\_\_ Sugar \_\_\_\_\_ Dairy products \_\_\_\_\_

Fatty food \_\_\_\_\_ Salty food \_\_\_\_\_ Cold raw food \_\_\_\_\_

Do you tend to eat under stress or when you are depressed? \_\_\_\_\_

Do you exercise regularly? Y\_\_N\_\_

What do you do to exercise? \_\_\_\_\_

Do you normally get enough sleep at night? Y\_\_\_N\_\_\_  
How many hours do you normally get each night? \_\_\_\_\_  
How is the quality of your sleep? \_\_\_\_\_  
Do you dream a lot? Y\_\_\_N\_\_\_  
If yes, do your dreams bother you? Y\_\_\_N\_\_\_  
Are you constantly under stress? Y\_\_\_N\_\_\_  
How do you manage your stress? \_\_\_\_\_

#### OTHER QUESTIONS

Is your skin sensitive to heat? \_\_\_\_\_  
Do you bruise easily? \_\_\_\_\_  
How are your emotions? \_\_\_\_\_  
Do you get nervous a lot? Y\_\_\_N\_\_\_      Do you get upset easily? Y\_\_\_N\_\_\_  
Do you feel sad easily? Y\_\_\_N\_\_\_      Do you get angry easily? Y\_\_\_N\_\_\_  
Do you get scared easily? Y\_\_\_N\_\_\_      Do you get excited easily? Y\_\_\_N\_\_\_  
Do you ever feel a lump in your throat? Y\_\_\_N\_\_\_  
If you are a woman, are you pregnant? Y\_\_\_N\_\_\_  
If you are a woman, please describe your menstrual cycle in detail (frequency, color, quantity of flow, any cramps, PMS, backaches etc.)  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
If you are a man over 50 years old, do you suffer from frequent urination?  
\_\_\_\_\_

Do you indulge in the following substances? If you do, how often?

Tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Recreational drugs \_\_\_\_\_

