YANINA ACUPUNCTURE CLINIC
INTAKE FORM

INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL

TODAY'S DATE____

NAME (FIRST/LAST)____

DATE OF BIRTH____

FULL MAILING ADDRESS____

____

PHONE NUMBER____

EMAIL____

EMERGENCY CONTACT AND PHONE NUMBER____

NAME OF YOUR PHYSICIAN AND CONTACT____

HOW DID YOU HEAR ABOUT US____

HEALTH CONCERNS YOU'D LIKE TO ADDRESS____

____

HOW LONG HAVE YOU HAD THIS CONDITION____

THE ONSET WAS (CIRCLE) GRADUAL SUDDEN

ARE YOU PREGNANT?____

DO YOU TAKE BLOOD THINNERS? ____

DO YOU HAVE A PACE MAKER____

PAST MEDICAL HISTORY (CIRCLE) HIV HIGH BLOOD PRESSURE CANCER DIABETES HEPATITIS

HEART DISEASE VENEREAL DISEASE THYROID DISEASE

MEDICATIONS YOU ARE TAKING____

____

SUPPLEMENTS YOU ARE TAKING____

____

ALLERGIES____

PAST SURGERIES ____

DO YOU SMOKE_____________________HOW OFTEN____
DO YOU DRINK_________________________HOW OFTEN____

ARE YOU TRYING TO GET PREGNANT____

PLEASE CIRCLE WHAT PERTAINS TO YOU

SLEEP : HARD TO FALL ASLEEP HARD TO STAY ASLEEP HARD TO WAKE UP

DIGESTION: BLOATING GAS CONSTIPATION DIARRHEA IRREGULAR BOWEL MOVEMENT IBS

ENERGY: TIRED LETHARGIC ENERGETIC HYPER

RESPIRATION/CARDIO/SKIN: SHORTNESS OF BREATH PALPITATION RESPIRATORY INFECTIONS
SKIN LESION ITCHINESS DRY SKIN DRY NAILS DRY HAIR

MENSTRUATION: REGULAR IRREGULAR LENGTH OF THE CYCLE_______________ BIRTH CONTROL __

TEMPERATURE PREFERENCE: HOT COLD