berlin
wellness group

Acupuncture Supplemental Intake form

Please note that all information is strictly confidential.

Name:______________________________ (last, first, MI) Today's date: ___/___/_____ (dd/mm/yyyy)

Date of birth:___/___/_____ (dd/mm/yyyy) Age: _______ Gender: Female ☐ Male ☐

Phone number: ____________________ Email address: ______________________________

Please list your major health concerns in order of importance:

1.____ since__________

possible cause____________________ treatments tried ____________________

2.____ since__________

possible cause____________________ treatments tried ____________________

3.____ since__________

possible cause____________________ treatments tried ____________________

Please list any health goals: ____

____

Relevant Family Medical History:

____

____

____

Lifestyle:

The general state of your health is:

- ☐ excellent
- ☐ good
- ☐ average
- ☐ fair
- ☐ poor

What do you do for work? ____

Hour of work/week? ____________________ Do you enjoy your work? ☐ Yes ☐ No

On average, describe your energy level (10= highest, 1= lowest) ________________

Do you exercise? ☐ Yes ☐ No What type/how often? ______________________________

What are your interests/hobbies? How often? ______________________________

____

Diet:

How many meals do you generally eat per day? ____________________

Who cooks/prepares your food? ____________________

List the primary foods included in your diet for:

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Beverages: ____________________

How much water do you drink each day? ____________________

List foods that you exclude from your diet and why: ____________________

List foods/flavors that you crave: ____________________

Have you had a bad reaction to any foods? ____________________

Are you satisfied with your diet/nutrition as it is now? Yes No

Sleep:

Do you have trouble falling asleep? Yes No

Time to bed: ____________ Time to rise: ____________

How many hours of sleep do you get per night? ____________

Are you rested in the morning? Yes No

Do you wake during the night? Yes No

Urination: Please circle any of the following symptoms you are currently experiencing:

Burning	Urgent	Retention	Scanty
Profuse	Dribbling	Greater than 1x a night	

Bowel Movements: Stools: Undigested food Blood Mucus

Frequency: When? ____________ Feels complete? Yes No

Consistency: Well-formed Hard Loose Alternates

Body Systems Review (please check all that apply):

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0 1 2 3 4	low appetite	0 1 2 3 4	ravenous appetite
0 1 2 3 4	loose stools	0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	mouth sores	0 1 2 3 4	fatigue after eating
0 1 2 3 4	abdominal gas/bloating after food	0 1 2 3 4	bruise easily
0 1 2 3 4	gums (bleeding/swollen)	0 1 2 3 4	thirst
0 1 2 3 4	organ prolapsed (diagnosed)	0 1 2 3 4	belching or vomiting

0 1 2 3 4	spontaneous sweat	0 1 2 3 4	fatigue
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	shortness of breath
0 1 2 3 4	general weakness	0 1 2 3 4	cough
0 1 2 3 4	dry nose/mouth/skin/throat	0 1 2 3 4	nasal discharge
0 1 2 3 4	feel worse after exercise	0 1 2 3 4	sinus congestion

0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	feel cold
0 1 2 3 4	low back pain	0 1 2 3 4	edema
0 1 2 3 4	frequent urination	0 1 2 3 4	urinary incontinence
0 1 2 3 4	early morning diarrhea	0 1 2 3 4	ear problems
yes no	impaired memory	yes no	hair loss
yes no	infertility	high normal	low libido

0 1 2 3 4	muscle spasms/twitches	0 1 2 3 4	irritable
0 1 2 3 4	feel better after exercise	0 1 2 3 4	numb extremities
0 1 2 3 4	tight feeling in chest	0 1 2 3 4	dry eyes
0 1 2 3 4	alternating diarrhea/constipation	0 1 2 3 4	ear ringing
0 1 2 3 4	symptoms worse with stress	0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension	0 1 2 3 4	red eyes

0 1 2 3 4	feel heart beating	0 1 2 3 4	chest pain
0 1 2 3 4	insomnia	0 1 2 3 4	disturbing dreams
0 1 2 3 4	sores on tip of tongue	0 1 2 3 4	headaches
0 1 2 3 4	anxiety	0 1 2 3 4	restlessness
0 1 2 3 4	chest pain traveling to shoulder		
high normal low	overall body temperature		
high normal low	overall energy level		

0 1 2 3 4	see floaters in eyes	0 1 2 3 4	foggy thinking
0 1 2 3 4	heat in palms or soles	0 1 2 3 4	dizzy upon standing
0 1 2 3 4	feeling of heaviness	0 1 2 3 4	nausea
0 1 2 3 4	afternoon fever	0 1 2 3 4	night sweats
0 1 2 3 4	enlarged lymph nodes	0 1 2 3 4	cloudy urine
0 1 2 3 4	face flushes		

Women Only:

At what age did you get your first period:_______ Date of last menstrual cycle? ________

Number of pregnancies _________ Number of births _________________

Are you currently on the Pill?.. Yes No

Are you pregnant now? .... Yes No

Number of days from the start of one period to the start of the next: __________________

Average number of days of flow: __________ Flow is: ☐ Light ☐ Normal ☐ Heavy

Color is: ☐ Pale ☐ Normal ☐ Dark ☐ Bright Red ☐ Brown

Does your period cause you pain or cramping? ☐ Yes ☐ No......When? ☐ Before ☐ During ☐ After Period

Do you get nausea or vomiting with your period? ☐ Yes ☐ No When? ☐ Before ☐ During ☐ After Period

Do you experience any of the following before your period each month? ☐ Water retention ☐ Breast tenderness or swelling ☐ depression ☐ Irritability ☐ Food cravings ☐ Migraines ☐ Other__________

Do you ever bleed or spot between periods? .... Yes No

Do your bowel movements become loose at the beginning of your period?.............................. Yes No

Have you ever had an abnormal pap smear? .... Yes No

Have you ever had a cervical biopsy, operation, cauterization, conization? .... Yes No

Have you ever had a venereal disease?... Yes No

Do you get yeast infections regularly? .... Yes No

Have you ever been diagnosed with a chlamydial infection?.. Yes No

Do you have unusual chronic vaginal discharge?... Yes No

Do you have any sores on your genitals? .... Yes No

Have you ever had pelvic inflammatory disease? .... Yes No

Were you treated for it? ☐ Yes ☐ No How____

Date of last pap smear? ______________________

Have you ever been diagnosed with uterine fibroids or polyps? .... Yes No

Have you ever been diagnosed with endometriosis?.. Yes No

Have you been diagnosed with pelvic adhesions?... Yes No

Have you been diagnosed with any pelvic abnormalities? .... Yes No

Have you taken any medications for gynecological conditions other than contraceptives?........ Yes No

Have you experienced menopause? ☐ Yes ☐ No When? ____________________

If you are experiencing menopausal symptoms, please describe:

____

____

Men Only:

Have you been diagnosed with prostate problems?.. Yes No

Do you experience premature ejaculation? .... Yes No

Do you have problems with Impotence? .... Yes No

Have you been diagnosed with Infertility?.. Yes No

Diseases/ Disorders:

____

____

Please explain any other information important to understanding your condition such as surgeries, injuries, or anything not listed above:

____

____

____

Thank you for taking the time to fill out this form thoroughly.
It will help us serve you better.

Signature: ______________________________ Date: _______________