Apex Massage and Wellness
3410 Frankfort Ave
Louisville, KY 40207
(502) 895-1262

# Acupuncture Intake Form

## General Information

Name_______________________________________________Date____________
Address______________________City_______________State_____Zip____________
Phone____________________ Occupation________________ Date of Birth___________
How did you hear about us?____________________ E-mail_______________________

## Medical Information

Please describe the main reason for your visit today______________________________
When did you first notice this?___________________________________________
Is it progressively getting worse/better?_____________________________________
Has there been a diagnosis?______________________________________________
List all medications you currently take?_____________________________________
______________________________________________________________________
Please list any major past or current medical issues or major traumas/diseases in your health history_________________________________________________________________
List any current allergies________________________________________________

Have you had any of the following?

| | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|
| Heart Disease | | | Chest/Lung Problems | | | Pregnancy Date of last____ | | |
| High Blood Pressure | | | Kidney Disease | | | Prostate Problems | | |
| Hepatitis/Liver Disease | | | Cancer____________ | | | Arthritis | | |
| High Cholesterol | | | Artificial Joints | | | Headaches/Migraines | | |
| Thyroid Disorder | | | Broken Bones | | | Seizures/Convulsions | | |
| Fainting/Dizziness | | | Mental Health Disorder | | | Anemia/Clotting | | |
| Diabetes | | | Substance Abuse Problem | | | Pacemaker | | |

## Family History

Please **one check** if a family member has had any of the following: Diabetes /Seizures Lupus /Stroke /Arthritis /Cancer /Heart Disease /Hypertension /Mental Disorders

Other________________________________ Comments______________________________

## Review of Symptoms

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue. Place **one check** next to a symptom you have experienced, **two checks** next to a frequently occurring symptom, and **three checks** next to a symptom that is particularly distressing to you.

**Head and Face**
Headaches
Dizziness
Memory Loss
Other____________

**Eyes**
Blurry Vision
Eyelid Twitching
Floaters
Pain
Other____________

**Nose**
Frequent Colds
Sinus Trouble
Bleeding
Other____________

**Mouth**
Dental Problems
Gum Problems
Teeth Grinding/TMJ
Unusual Tastes
Other____________

**Heart and Chest**
High Blood Pressure
Low Blood Pressure
Chest Pain
Chest Tightness
Difficulty Lying Down
Other______________

**Circulation**
Easy Bruising
Easy Bleeding
Cold Limbs - Hands or Feet
Reynaud's Syndrome
Other______________

**Gastrointestinal**
Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain
Nausea
Diarrhea/Loose Stools
Constipation
Rectal Bleeding
Colon Problems
Other______________

**Skin**
Acne
Dryness
Moles that Change
Lumps
Excessive Sweating
Night Sweats
Rarely Sweat
Other________________

**Neurological**
Nervousness/Anxiety
Tremors
Numbness or Tingling
Lack of Coordination
Nerve Pain
Other________________

**Throat**
Sore throat
Hoarseness
Difficulty Swallowing
Dryness
Other_____________

**Respiration**
Difficulty Inhaling
Difficulty Exhaling
Pain
Cough
Congestion
Shortness of Breath
Other_____________

**Urination**
Frequent
Difficult
Painful
Nocturnal
Bleeding
Other______________

**Sleep**
Insomnia
Drowsiness
Excessive Dreaming
Waking Easily
Other________________

Pain – Please describe________________________________________________

Are there any other health concerns? ____________________________________

Parent/Guardian Signature____________________________ Date____/_____/_____

Printed Patient Name_____________________ Signature_________________________