



Client Intake Form *(long form)*

Name: _____ Today's Date: _____

Age _____ Birth date: _____

Location of Birth _____ of Childhood: _____

Please indicate birth gender: M F Please indicate current gender identity: M F Other

Current Height _____ Weight: _____ Any recent significant changes to weight & when? _____

Relationship Status: _____ Number of Children: _____

Occupation(s): _____

Phone: _____ Email: _____

Mailing Address: _____

Emergency contact name & phone number: _____

I give *Rosewood Acupuncture & Ayurveda, LLC* and their online scheduling software permission to email and/or text me appointment notifications and occasional announcements -Please note that our online scheduling software requires your phone and email in order to automatically confirm appointments and send reminders. You are responsible for providing that information and changing it if/when necessary.

Primary Health Concerns:

PRIMARY CONCERNS: List by order of importance to you. Please note when the condition/symptoms started and to what degree they interfere with your activities of daily living

1.
2.
3.
4.

MEDICAL HISTORY

- Have you had acupuncture before? Yes No
 - Do you have a **bleeding disorder** that affects clotting & bleeding time? Yes No
 - Are you currently on **anti-coagulant drugs** (warfarin, heparin, etc)? Yes No
 - Is there any possibility that you are currently **pregnant**? Yes No
 - Are you trying to become **pregnant**? Yes No
 - Are you currently **breastfeeding**? Yes No
 - Do you have any **implanted medical devices** (ex: pacemaker)? Yes No
 - Do you have a history of **needle shock** (fainting with needles)? Yes No
 - Do you experience **seizures**? Yes No
 - Have you been under the care of a licensed health care professional in the past year?** Yes No
- If so, for what reasons/conditions?*

Please List All:

1. **Notable and/or serious illnesses, trauma, Injuries:**

2. **Hospitalizations & Operations:**

3. **Allergies:**

4. **List any other pertinent past & present conditions** (please include chronic infections –Hepatitis B/C, MRSA, HIV/AIDS, etc):

Medications, Herbs and Supplements taken regularly, dose, what they are for: (please include birth control pills & allergy medications. Please note long-term or frequent use of antibiotics):

Item	What for	Dose & time taken

FAMILY HISTORY Please check the appropriate boxes and indicate family member.

Condition	Self	Family Member	Condition	Self	Family Member
Cancer (type)			Diabetes (type)		
High Blood pressure			Heart Attack // Heart disease		
Stroke (type)			High Cholesterol		
Tuberculosis			Depression // Anxiety		
Thyroid disease (type)			Other mental health issues		
Hepatitis			Suicide/Suicide attempts		
Anemia			Alcohol or Substance abuse		

Caffeine? Source, amount/day:

Smoking? What, how much/day:

History of smoking cigarettes (include quit date if applicable):

Alcohol consumption (what type, amount, frequency):

Drug use (what type, amount, and frequency. *If there is a significant history of drug use, please note this and the substance used*):

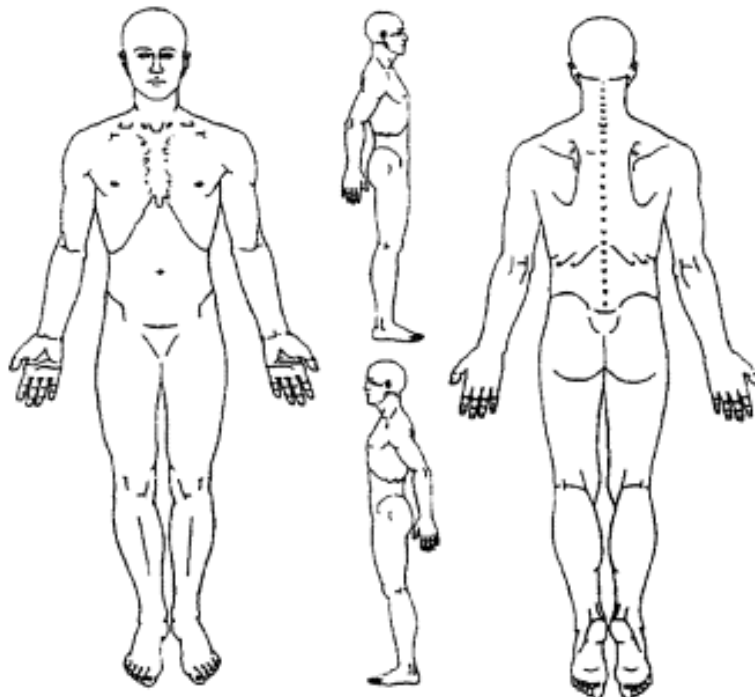
What type(s) of exercise do you engage in and how often?

Current Stress Level (on a scale of 0-10):

Do you often feel highly stressed?

How & where do you experience the stress in your body (ex: shoulders, digestion)?

Please mark the areas where you experience pain or discomfort:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fevers	<input type="checkbox"/> Chills
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Tremors	<input type="checkbox"/> Cravings	<input type="checkbox"/> Change in appetite	
<input type="checkbox"/> Poor balance	<input type="checkbox"/> Bleed or bruise easily	<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	
<input type="checkbox"/> Peculiar tastes	<input type="checkbox"/> Desire hot food	<input type="checkbox"/> Desire cold food	<input type="checkbox"/> Strong thirst (cold or hot drinks)		
<input type="checkbox"/> Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____					
Skin & hair	<input type="checkbox"/> Rashes	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Hives	<input type="checkbox"/> Itching	<input type="checkbox"/> Eczema
<input type="checkbox"/> Pimples	<input type="checkbox"/> Acne	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Recent moles	<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Purpura	<input type="checkbox"/> Change in hair or skin texture		<input type="checkbox"/> Other?		
Musculoskeletal	<input type="checkbox"/> Joint disorders	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Pain/soreness in the muscles	<input type="checkbox"/> Tremors	
<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Swelling of hands/feet	<input type="checkbox"/> Spinal curvature	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hernia
<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Neck tightness	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shoulder pain
<input type="checkbox"/> Hand/wrist pain	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Joint Sprain	<input type="checkbox"/> Other?	
Head, eyes, ears, nose, and throat	<input type="checkbox"/> Dizziness		<input type="checkbox"/> Concussions	<input type="checkbox"/> Migraines	<input type="checkbox"/> Glasses/lens
<input type="checkbox"/> Eye strain	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Color blindness	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Earaches	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Spots in front of eyes	
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeding	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Facial pain
<input type="checkbox"/> Jaw clicks	<input type="checkbox"/> Sores on lips/tongue	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Other?		
Cardiovascular	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Fainting
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Other?	
Respiratory	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Difficulty breathing	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Production of phlegm – What color? _____		
Gastrointestinal	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Gas
<input type="checkbox"/> Belching	<input type="checkbox"/> Black stools	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Rectal pain
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Abdominal pain/cramps	<input type="checkbox"/> Gallbladder problems	<input type="checkbox"/> Parasites	<input type="checkbox"/> Chronic laxative use	
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____					
Neuro-psychological	<input type="checkbox"/> Loss of balance		<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Concussion	
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stress	<input type="checkbox"/> Bad temper	<input type="checkbox"/> Bi-polar	
Genital-urinary	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Urgency to urinate	
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Pause of flow	<input type="checkbox"/> Frequent urinary tract infection	
<input type="checkbox"/> Genital pain	<input type="checkbox"/> Genital itching	<input type="checkbox"/> Genital rashes	<input type="checkbox"/> STD	<input type="checkbox"/> Other?	

Dietary Restrictions: ((Vegan)) ((Vegetarian –eggs, dairy, etc)) ((Omnivore)) ((Gluten-free))
((Diet high in vegetables)) ((Favor Organic foods)) ((Favor non-organic foods))

**Are you regularly eating commercial/feedlot/factory-farmed animal products?*

**Do you regularly consume processed foods and/or a high sugar diet?*

**Are you aware of the health concerns associated with GMO (genetically modified) foods?*

Meals: Please indicate the general time of day for each meal and the commonly eaten foods for each meal

Breakfast:

Lunch:

Dinner:

Snack(s):

Appetite: ((high)) ((low)) ((variable))

Do you regularly experience cravings? What foods/flavors do you crave?

Thirst: ((High)) ((Low)) **How much water do you drink daily?** _____

Temperature preference of drinks: ((Icy)) ((Room Temperature)) ((Warm))

Digestion: ((Gas)) ((Bloating)) ((Heartburn)) ((Acid Reflux/GERD))

Bowel Movements: How often & what time of day, consistency/color, undigested food bits?
((Constipation)) ((Diarrhea)) ((IBS))

For women only:

Duration of typical cycle (from day 1 of menses until menses starts again): _____

Do you practice Birth Control? What type? _____

Do you experience PMS? Please indicate symptoms such as bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc. _____

Do you experience and/or have a history of: check all that apply

Irregular periods		Polycystic Ovaries (PCOS)	
Fibroid Cysts on uterus		Endometriosis	
Vaginal Discharge		Fertility Challenges	
Painful breasts		Fibrocystic Breast changes	
Clotting with menses		Bleeding between periods	
Menstrual Cramps		Hot Flashes	
Pain with sex		Night Sweats	
(other)		(other)	

Age at first menses _____ # of pregnancies _____ # of births _____

of miscarriages _____ # of abortions _____ # of C-Sections _____

Have you been through menopause? Age? _____

Have you had a hysterectomy (full or partial)? _____

Do you use Hormone Replacement Therapy (HRT)? *This question also applies to transgender clients* _____

For men only:

Prostate Issues?

Urinary hesitancy related to prostate issues?

Erectile dysfunction/impotence?

Fertility challenges?

Ejaculatory pain?

Do you or have you used medication to stop/slow balding?

What would you most like to get out of your work with us?

Is there anything else you would like to tell us about that was not covered above?

Cancellations and Financial Policy Agreement

1. We do not bill insurance companies for goods or services at this time. Upon request, we are happy to provide you with a receipt that you can send to your health insurance provider.
2. Our current prices are listed on our website www.rosewoodacupuncture.com in the “**Services**” section and also on our online booking/appointment system. Payment is expected in full at the time of the appointment.
3. Prices for goods and services may change periodically to reflect changes in the cost of doing business. We will always strive to keep prices affordable and to honor the loyalty of our regular customers. Please let us know if we need to discuss pricing options or a sliding scale fee in order to make treatment possible.
4. We accept **credit cards**, **checks** and **cash** for payment.
5. If you must miss or reschedule an appointment, please make every attempt to notify us at least 24 hours in advance so that we can book another client into the time slot. Multiple last minute cancellations may require pre-payment for future bookings. Exceptions will be made for legitimate emergencies and unforeseen circumstances.

I have read and understand the Financial and Cancellation policies

I have completed this form correctly to the best of my knowledge

Signature Adult patient Parent or Guardian Spouse

Date