ANTHONY FARLEY
ACUPUNCTURE HERBS MASSAGE

New Patient Intake Form

Full Name:_____ Today's Date: _____

Age:_____ Occupation:_____

Email:_____ Phone:_____

Address:_____

Postcode:_____

General Questions

Have you ever had acupuncture before? Yes ☐ No ☐

Chief complaint:_____

How long have you had this condition?_____

What seemed to be the intial cause?_____

What seems to make it better?_____

What seems to make it worse?_____

Describe your pain: Dull ☐ Stabbing ☐ Sharp ☐ Shooting ☐ Burning Other_____

What makes the pain better? Heat ☐ Cold ☐ Pressure ☐ Movement ☐ Massage ☐ Rest ☐

On a scale from 1-10 how would you rate the pain? _____

Family Medical History

Allergies (please list) _____

Arteriosclerosis ☐ Cancer ☐ Diabetes ☐ Siezures ☐ Asthma ☐ Heart Disease ☐ Stroke ☐

High Blood Pressure ☐ Alcoholism ☐ Other_____

Are you currently on any medications? Yes ☐ No ☐ Please list_____

_____

Are taking any vitamins or suppliments? Yes ☐ No ☐ Please list_____

_____

Your Past Medical History (check any that you have, or have had)

Arthritis ☐ Asthma ☐ Allergies ☐ Appendicitis ☐ Blood Pressure (high/low) ☐

Cancer ☐ Diabetes ☐ Depression ☐ Emphysema ☐ Epilepsy ☐ Endometriosis ☐

Eczema/skin issues ☐ Goiter ☐ Gout ☐ Heart Issues ☐ Liver Disease/Hepatitis ☐

Kidney Disease ☐ Mental Illness ☐ Migraines ☐ Siezures ☐ Stroke ☐

Thyroid Disorders ☐ Ulcers ☐ Urinary Infections ☐

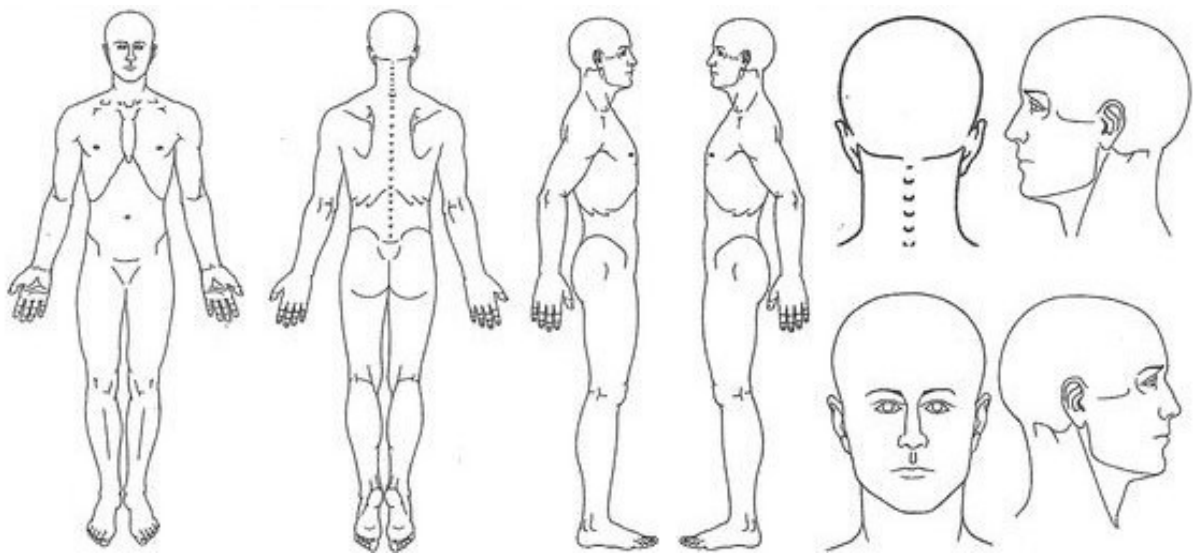
Surgeries? Please list _____

_____

Major Trauma? _____

_____

Please circle where you feel your issue:



Please list any other pertinant information:_____

_____

_____

I agree that the information that I've provided on this page is true and accurate. It is my responsabiltiy to inform my acupucnturist at any point during my course of treatments if any information has changed.

Signature of Patient_____ Date_____