Lackafinna Acupuncture

Patient Intake Form

Name: _____

Address: _____

_____

Phone: _____ **Email:** _____

Date of Birth: _____

Please fill out the following medical history questions as accurately as you can

What is your principal complaint: _____

_____

What is the diagnosis (if any) by GP: _____

_____

Birth history (any medical procedures or medications?)_____

_____

Vaccination history (any reactions to vaccines? Unusual vaccinations?) _____

_____

Childhood Illnesses (0-12) any surgeries, accidents, major events? Please list in chronological order

Age: _____ _____

Age: _____ _____

Age: _____ _____

Age: _____ _____

Adolescence Illnesses (12-18) any surgeries, accidents, major events? Please list in chronological order

Age: _____ _____

Age: _____ _____

Age: _____ _____

Age: _____ _____

Adulthood Illnesses surgeries, accidents, major events? List in chronological order and indicate duration

Age: _____ _____

_____

Age: _____ _____

_____

Age: _____ _____

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Age: _____ _____

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Age: _____ _____

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Age: _____ _____

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Age: _____ _____

_____

Family History: Please note all major illnesses in your immediate family (parents, grandparents), e.g., diabetes, heart disease, hypertension, neurological, blood, psychological, or orthopedic disorders, etc.

_____

_____

_____

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_____

_____

Are you taking any medications? Please note any medications even if you are taking them only occasionally. Also include medications taken in the past. (This includes birth control.)

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____