HOSTA LANE
ACUPUNCTURE

Patient Information Intake Form

Date:	
Name:	
Address:	
Home Phone:	
Mobile Phone:	
Email:	
Emergency Contact Name: Phone: Relationship:	

Date of Birth: (M/D/Y)	Age:	Height:	Weight:

Gender:	Preferred Pronoun:
Occupation:	

Health History:	Please list your health concerns and complaints in order of importance.
1.	
2.	
3.	
Have you discussed with your physician about receiving acupuncture treatment? Yes ☐ No ☐	

Do you have a contagious disease at this time?	Yes☐ No ☐
If yes, please specify:	
Allergies: ☐ Yes ☐ No Please List:	
Medications:	
Foods:	
Other:	

Please list any medications or supplements that you are taking:

Have you ever had surgery or have been hospitalized? ☐ Yes ☐ No If yes, please describe.

Information needed for treatment:

☐ Pacemaker	☐ Skin infection	☐ Pregnant
☐ Medication pump	☐ Bleeding disorder	☐ Needle phobia

Lifestyle:

Caffeinated Drinks? (Coffee, tea, pop)	Yes ☐ No ☐	If yes, how much daily?	
Alcohol?	Yes ☐ No ☐	If yes, how much daily?	
Smoking?	Yes ☐ No ☐	If yes, how much daily?	
Cannibis? CBD or THC?	Yes ☐ No ☐	If yes, how much daily?	
Other? (specify)	Yes ☐ No ☐	If yes, how much daily?	

Exercise & Activity:

Type/Description	Amount

Please check any boxes that are relevant to your health:

☐ Diabetes	☐ Fibromyalgia	☐ Chronic fatigue
☐ High Blood Pressure	☐ Nausea	☐ Stomach cramps
☐ Low Blood Pressure	☐ Vomiting	☐ Ulcers
☐ Fainting	☐ Diarrhea	☐ Enteritis
☐ Light headedness	☐ Constipation	☐ Gastritis
☐ Chest Pain/Angina	☐ Undigested food in stools	☐ Ulcerative Colitis
☐ Slow Heartbeat	☐ Irritable Bowel Syndrome	☐ Rectal pain
☐ Fast Heartbeat	☐ Acid reflux	☐ Burning anus
☐ Irregular Heart rate	☐ Gas	☐ Hemorrhoids
☐ Palpitations	☐ Hiccups	☐ Itchy anus
☐ Orthostatic Hypotension	☐ Bloating after meals	☐ Black stools
☐ Phlebitis	☐ Intestinal cramping	☐ Mucus in stools
☐ Heart Attack	☐ Laxative use	☐ Blood in stools
☐ Stroke or TIA	☐ Clotting disorder (DVT)	☐ Cancer
☐ Other:		

Head, Eyes, Nose and Throat:

☐ Glasses	☐ Red eyes	☐Spots in eyes
☐ Eye strain	☐ Itchy eyes	☐ Floaters in vision
☐ Poor vision	☐ Night blindness	☐ Glaucoma
☐ Blurred vision	☐ Sinus problems	☐ Nosebleeds
☐ Cataracts	☐ TMJ	☐ Poor hearing
☐ Headaches	☐Grinding teeth	☐ Ringing in ears
☐ Migraines	☐ Soft teeth	☐ Earaches
☐ Concussions	☐ Multiple cavities	☐ Sore gums
☐ Dry mouth	☐ Sores on lips	☐ Bleeding gums
☐ Recurrent sore throat	☐ Sores on tongue	☐ Gum disease
☐ Excessive saliva	☐ Feels like something in throat	☐ Clears throat often
☐ Lumps in throat	☐ Enlarged thyroid	☐ Swollen glands

Respiratory conditions:		
☐ Short of breath	☐ Difficulty breathing laying down	☐Lightheaded
☐ Chest pain	☐ Fast heartbeat	☐ Palpitations
☐ Productive cough with:	☐ A lot of sputum	☐ Very little sputum
☐ Sticky sputum	☐ Clear sputum	☐ Green sputum

Sleep patterns:	Usual bedtime:	Usual awake time:
☐ Insomnia	☐ Problems falling asleep	☐ Problems staying asleep
☐ Dream disturbed sleep	☐ Nightmares	☐ Pain during sleep
☐ Waking up in the night What time?		

Dermatological conditions:		
☐ Rashes	☐ Eczema	☐ Fungal infections
☐ Hives	☐ Psoriasis	☐ Acne
☐ Shingles	☐ Itchy skin	☐ Ulcerations
☐ Dry Skin	☐ Oily skin	☐ Alopecia/Hair loss
☐ Brittle dry hair	☐ Premature grey hair	☐ Warts

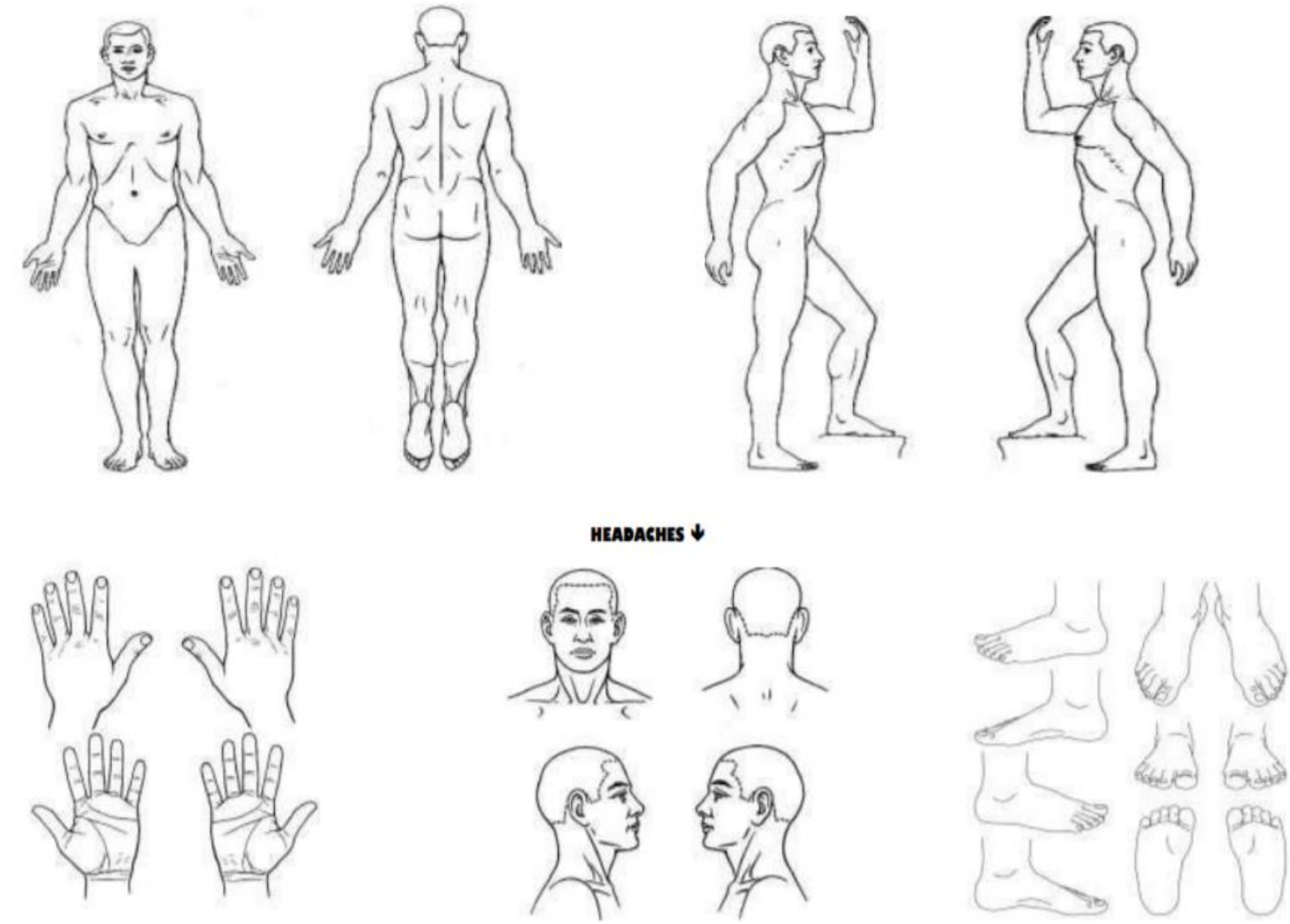
Genital and Urinary conditions:		
☐ Painful urination	☐ Frequent urination	☐ Copious urination
☐ Scanty urination	☐ Urination at night	☐ Burning urination
☐ Frequent bladder infections	☐ Frequent kidney infections	☐ Urinary tract infections
☐ Urine incontinence	☐ Dark yellow urine	☐ Light yellow urine
☐ Retention of urine	☐ Blood in urine	☐ Clear urine

Neuropsychological conditions and Mental Health:		
☐ Seizures	☐ Tics	☐ Parkinson’s
☐ Numbness	☐ Tingling	☐ Trigeminal neuralgia
☐ Bell’s Palsy	☐ Anxiety	☐ Depression
☐ Irritability	☐ Easily stressed	☐ ADHD
☐ Memory loss	☐ PTSD	☐ Mental Health Issues

Sexual and Reproductive Health:	Check if applicable
☐ Sexually transmitted disease	☐ Testicular pain
☐ Impotence/Erectile Dysfunction	☐ Prostate problems
☐ Regular Menstruation	☐ Spotting/Bleeding between cycles
☐ Pre-Menstrual Syndrome (PMS)	☐ Menopausal issues (Pre or Post menopause)
☐ Painful menstruation	☐ Heavy/Excessive menstruation
☐ Clots during menstruation	☐ Excessive vaginal discharge between cycles
☐ Breast pain	☐ Breast lumps
Birth Control pills: ☐Yes ☐No	
Are You Pregnant? ☐Yes ☐No Planning to get pregnant? ☐Yes ☐No	
Have you been pregnant? ☐Yes ☐No	
Number of pregnancies:	Problems in pregnancy: ☐Yes ☐No
Number of miscarriages:	Problems in delivery: ☐Yes ☐No
Post-partum depression: ☐Yes ☐No	
If you had problems with a pregnancy or delivery, please describe:	

Musculoskeletal conditions:		
☐ Neck pain	☐ Hand pain	☐ Hip pain
☐ Shoulder pain	☐ Finger pain	☐ Leg pain
☐ Arm pain	☐ Chest pain	☐ Knee pain
☐ Elbow pain	☐ Rib pain	☐ Ankle pain
☐ Wrist pain	☐ Flank pain	☐ Foot pain
☐ Upper back pain	☐ Abdominal pain	☐ Toe pain
☐ Mid back pain	☐ Fatigue	☐ Burning pain
☐ Low back pain	☐ Stiffness	☐ Muscle soreness
☐ Arthritis pain	☐ Pain worse with movement	☐ Pain better with movement
☐ Joint Swelling	☐ Pain worse in morning	☐ Pain worse at night
☐ Recent accidents or falls	☐ Pain worse with cold	☐ Pain better with cold
☐ Other	☐ Pain worse with heat	☐ Pain better with heat

Please indicate areas of pain or concern:



Describe your concern: