InCircle Community Acupuncture

3575 Donald St., Suite 100, Eugene, OR. 97405

Initial Visit Intake

Patient Information

Name: _____ DOB: __/__/__ Date of Visit: __/__/__

Address: _____ Home Phone: _____

City, State, ZIP: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Primary Care Physician: _____ Physician Phone #: _____

Emergency Contact Info:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Health History

Primary health concerns you would like to address:

1. _____
2. _____
3. _____

List of current medications and supplements:

_____ _____

_____ _____

_____ _____

Serious illnesses, accidents, injuries: Date of:

1. _____ _____
2. _____ _____
3. _____ _____

Hospitalizations, surgeries, major procedures:: Date of:

1. _____ _____
2. _____ _____
3. _____ _____

On a scale of 1 - 10 (1 = lowest, 10 = highest) please rate your:

Stress Level: _____ Sources of stress: _____

Pain Level: _____ Sources of pain: _____

On a scale of 1 - 10 (1 = poor, 10 = excellent) please rate your:

Sleep Quality: _____ Diet: _____ Exercise Routine: _____

Alcohol Use: ___ drinks/day ___ drinks/week. Tobacco Use: ___cigs/day ___cigs/week

Digestive Health

Do you experience any of the following:

____bloating ____stomach cramps ____ gas _____ acid reflux ____ poor appetite

Stools:

____ sink ____ float ____loose ____ constipation ____ bad odor ____ blood In stool

Foundations:

On a scale of 1 - 10, 1 = poor 10 = excellent, please rate your:

Energy Level: _____

Exercise Routine: _____

Hydration: _____

Libido: _____

Appetite: _____

Emotional Health:

___ Depression __ Anxiety __ PTSD __ Irritability __ Mood Swings

Check illnesses that have occurred in your Family (siblings, parents, grandparents)

__ Diabetes __ Cancer __Stroke __ Heart Disease __ Kidney Disease

Please mark the following symptoms: 1 - IF CURRENT 2 - IF PAST

__ asthma	__ Crohn's	__ palpitations	__ migraines
__ allergies	__ IBS	__ tightness in chest.	__ headache
__ pneumonia	__ diarrhea	__ arteriosclerosis	__ depression
__ frequent colds	__ constipation.	__ hypoglycemia	__ anxiety
__ Epstein Barr	__ blood in urine	__ eating disorder.	__ addiction
__ AIDS	__ colitis	__ TMJ	__ dizziness
__ fibromyalgia	__ chronic fatigue	__ tinnitus	__ stroke
__ MS	__ weight loss	__ hearing loss	__varicosities
__ heart pain	__ weight gain	__ sinusitis	__ hemorrhoids
__ high blood pressure	__ parasites	__ sciatica	__ hepatitis
__ arthritis	__ osteoporosis	__ memory loss	__ fatty liver
__ low grade fever	__ dry skin	__ poor circulation	__ nephritis
__ nose bleeds	__ rash/itchy skin	__ eye pain	__ herpes

FOR MEN ONLY: 1 - IF CURRENT 2 - IF PAST

__ prostate problems

__ penis discharge

__ erectile dysfunction

FOR WOMEN ONLY:

Age of First Menses: _____ Birth Control: _____

Length of Cycle: _____ Flow lasts how many days: _____

Regular? _____ Light ____ Heavy ___ Clots? _____ Color of blood: _____

PMS? describe… _____

Irregularity describe: _____

Age of last menses: _____

Menopausal Symptoms: _____

Please mark the following 1 IF CURRENT 2 IF PAST

__ hysterectomy	__ herpes	__ mastectomy	__ lumpectomy
__ fibroids/cysts	__ yeast infection	__ infertility	__ PCO