Acupuncture/Cupping Intake Forms

Date MM/DD/YYYY ______/________/______________

Last Name:______________________________________ First Name:_______________________________

Address:____

City:________________________ Province:______________________ Postal Code: :____________________

Home Phone:(______)_________-__________ Cell Phone:(______)_________-___________

Email: ___________________________________ Date of Birth MM/DD/YYYY______/_______/_________

Occupation: ____ Gender: M F

Reason for your appointment? ____

When did your condition begin? :____

Have you been treated by other health professionals for this issue? Yes No

If yes, by whom? :____

Is your condition due to a motor vehicle accident? Yes No

Do you have any allergies? ____

Please list any medications you are currently taking:

____

Do you have a cardiac pacemaker? Yes No

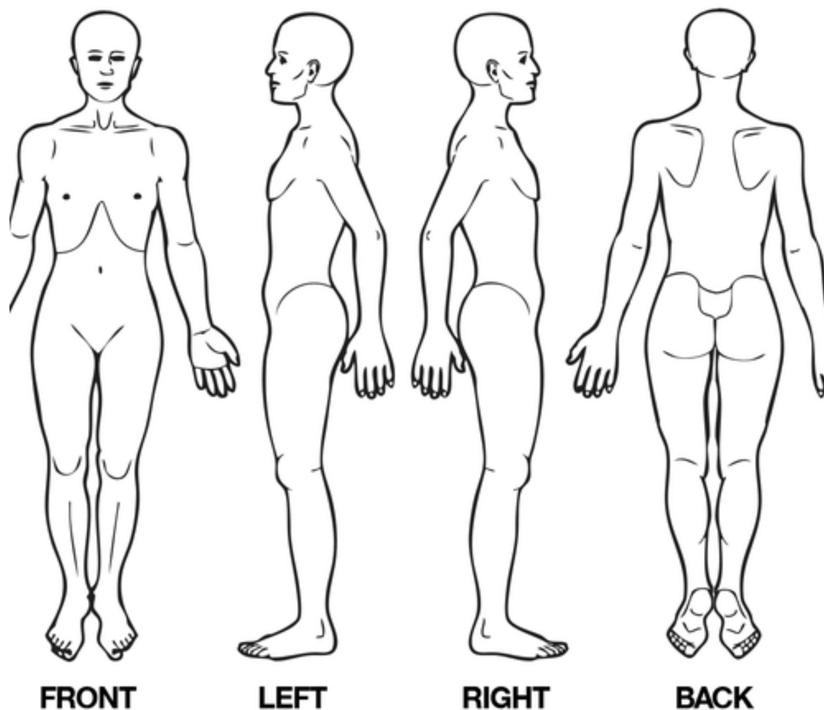
Do you have difficulty falling asleep or staying asleep? Yes No

Do you have lower energy levels than normal? Yes No

Do you have digestive disturbances? Yes No

Rate your stress level: 1 2 3 4 5 6 7 8 9 10

Please circle any areas of pain or discomfort and rate the severity on a scale from 1 – 10:



Please check any conditions you have had previously or are currently experiencing:

- ☐ Diabetes
- ☐ Cancer
- ☐ Hepatitis
- ☐ Blood Clots
- ☐ Shingles
- ☐ HIV/AIDS
- ☐ Pregnancy
- ☐ Migraines
- ☐ Arthritis
- ☐ Clotting Disorders
- ☐ Hemorrhoids
- ☐ Palpitations
- ☐ Allergies
- ☐ Vision Troubles
- ☐ Dizziness
- ☐ Anxiety
- ☐ Night Sweating
- ☐ Asthma