Acupuncture Intake Form

Client Information

First Name	Last Name	Date of Birth	Patient Identifier (If known)
Gender	Preferred Pronouns	Email	Preferred Phone Number

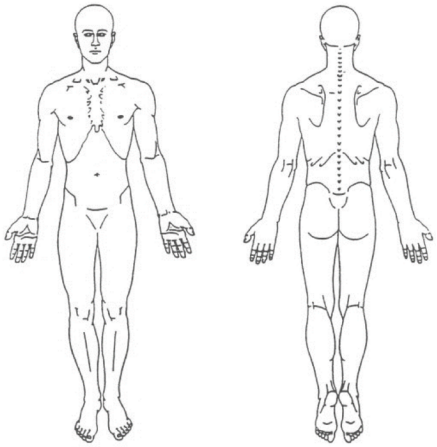
Address	City	State	Zip Code

Emergency Contact

Full Name	Relationship	Contact Number
Full Name	Relationship	Contact Number

Health Information

Spasm
Inflammation
Trigger Point
Elevation
Adhesion
Rotation
Pain
Tender Joint
Hypertonicity



Client Concerns

Rate your current pain on a scale from 1 (least) to 5 (worst)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Indicate the type of pain you are facing

☐ Sharp ☐ Piercing ☐ Aching ☐ Numbness ☐ Dull ☐ Shooting ☐ Tingling ☐ Stabbing

☐ Other, Please Specify: _____

Current Medical Conditions	Past Medical Concerns
Relevant Family History	Current Injuries
Past Injuries	Allergies

Signature	Date