Initial Intake Form

Julienne' Gienger Licensed Acupuncturist
218A South Churton Street Hillsborough, NC 27278 - 919-356-4639

Today's date _____/_____/________

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

General Information:

Name____ Birthdate____/____/_____

Sex/Gender_____Marital Status___________#children ___ /age(s) ___________________

Address____

Phone numbers (please mark * next to best number):

Home_____________________Cell_____________________Work___________________

E-mail____

email is necessary to use our confidential online scheduling system

How did you hear about us? ____

If via person, name:____________________________May we send a thank you card? □ Y □ N

Emergency Contact

Name_______________________________________Ph____________________________

Relationship___________________

If Under 18 ---Responsible Party Information

Name____

Relationship to Patient______________________________________

Previous experience with acupuncture? □ Y □ N / Name and results_________________________________

Health History

Please list your major health concerns in order of importance to you:

____

____

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

____

____

____

____

Family History (List any family physical or mental illnesses and age of death):
Mother____

Father____

Grandparents____

Siblings____

Children____

Medications, Herbs, Supplements (List those you are currently taking):

Name__________________Reason _________________________How long and Dose______________

Name__________________Reason _________________________How long and Dose______________

Name__________________Reason _________________________How long and Dose______________

Name__________________Reason _________________________How long and Dose______________

Name__________________Reason _________________________How long and Dose______________

Name__________________Reason _________________________How long and Dose______________

Lifestyle Habits

Dietary Restrictions____

Special diet____

What is the major source of joy in your life? ____

____

What is the major source of stress in your life? ____

____

Fill in the Blank: Yes/No or Quantity (#)

Average hours sleep?_______

Supportive relationships?_______

Have a history of abuse?_______

Enjoy your work?_______

Take vacations?_______

Spend time outside?_______

Exercise?_______

Hours watch TV?_______

Read Books?_______

Computer/Video games?_______

How many meals a day?_______

Smoke cigarettes now/past/#day?_______

Drink coffee/How much?_______

Drink tea/How much?_______

Drink soda/How much?_______

Drink alcohol/How much?_______

Use recreational drugs?_______

Addiction/Substance?_______

Been outside the U.S. in past 12 months?________________

Spiritual/religious practice?_______

What are your goals for your health?

____

____

____

Please circle your level of commitment to correcting your health issues? (10 = highest level)
1 2 3 4 5 6 7 8 9 10

For the following chart, mark the appropriate squares in the following list of symptoms that you have had past/present:

Fire Element	Earth Element	Metal Element	Water Element	Wood Element
□ Heart Palpitations	□ Body Heaviness	□ Bloody Cough	□ Urinary Problems (i.e. night-time)	□ Depression/Stress
□ Rapid or Irregular Heartbeat	□ Hard to get up in Morning	□ Dry Cough	□ Bladder Infection	□ Headaches/Migraines
□ Chest Pain	□ Muscles Often Feel Tired	□ Chronic Cough	□ Incontinence	□ Red/Dry/Itchy Eyes
□ High Blood Pressure	____ Energy Level: 1-10 (low to high)	□ Cough with Sputum	□ Weakness/Pain in Low Back	□ Visual Problems/ Blurred Vision
□ Low Blood Pressure	□ Edema(□Hands □Feet)	□ Nasal Discharge □White □Yellow □Green □ Post Nasal Drip	□ Osteoporosis	□ Dizziness
□ Insomnia/Sleep Problems	□ Easily Bruising/ Bleeding	□ Sinus Infection / Congestion	□ Feel Cold or Hot Easily	□ Gall Stones
□ Vivid Dreams/ Nightmares	□ Bad Breath	□ Itchy, Red, or Painful Throat	□ Cold Hands/Feet	□ Feeling of Lump in Throat
□ Easily Startled	□ Sweetish Taste in Mouth	□ Dry Mouth/Nose/ Throat	□ Low or Excess Sex Drive	□ Clenching Teeth at Night
□ Dark Urine	□ Lack of Taste	□ Skin Rashes/Hives	□ Dark Circles under Eyes	□ Muscle Cramping/ Twitching
□ Red Complexion	□ Excess or Low Appetite	□ Snoring	□ Thyroid Problems	□ Neck/Shoulder Pain/ Tightness
□ Do you crave: Bitter	□ Excess or Lack of Thirst	□ Shortness of Breath	□ Poor Memory	□ Seizures/Tremors
□ Anxiety / Nervous or Restless	□ Nausea / Vomiting	□ Allergies/Asthma	□ Hair Loss/Grey Hair	□ Poor Circulation
□ Hyperactivity	□ Gas/Belching	□ Low Immunity	□ Hearing Problems/ Tinnitus	□ Soft/Brittle Nails
□ Excessive daydreaming	□ Hemorrhoids	□ Catch Colds Easily	□ Cavities	□ Bitter Taste in Mouth
□ Loud Voice	□ Organ Prolapse (i.e. uterus)	□ Bronchitis	□ Hot Flashes/Night Sweats	□ PMS/Menstrual Problems
□ Laughing (inappropriate)	□ Chronic Loose Stools	□ Black or Bloody Stools	□ Impotence or Premature Ejaculation	□ Tendonitis
□ Impulsive	□ Abdominal Pain	□ Constipation	□ Do you crave: Salt	□ Pain Below Ribcage
□ Hormone imbalances	□ Indigestion/Heartburn	□ IBS	□ Fears	□ Do you crave: Sour
□ Addictive personality	□ Brain Foggy/Poor Memory	□ Diarrhea		□ Tend to be Irritable/ Angry
	□ Mouth Ulcers	□ Colitis / Spastic Colon		
	□ Tendency to Gain Weight	□ Do you crave: Pungent/Spicy		
	□ Do you crave: Sweet	□ Grief/Sadness		
	□ Over-thinking/Worry			