RECHARGE
MOBILE ACUPUNCTURE

New Patient Intake Form

Personal Information:

Name: _____

Date of Birth: _____

Age: _____

Gender: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Email: _____

Phone: _____

Medical History:

Primary Reason for Seeking Acupuncture: _____

Brief Description of Symptoms/Concerns: _____

Please check any of the following conditions you have or had in the past (mark all that apply):

Headaches/Migraines - Digestive Issues - Sleep Disorders
Chronic Pain - Anxiety/Depression - Respiratory Problems
Allergies - Menstrual Issues - High Blood Pressure
Other: _____

Please list any medications or supplements you are currently taking: _____

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Have you received acupuncture treatments before? Yes No

If yes, when was your last acupuncture treatment?

Have you ever had an adverse reaction to acupuncture or any other complementary therapies? Yes No
If yes, please describe:

Do you have any medical conditions or concerns that you think are relevant to your acupuncture treatment? Please provide details: _____

Lifestyle and Habits:

Do you exercise regularly? Yes No

If yes, what type and how often?

How would you describe your diet? _____

Do you smoke? Yes No
If yes, how many cigarettes per day?

Do you consume alcohol? Yes No
If yes, how many alcoholic drinks per week?

Additional Information:

How did you hear about our clinic? _____

Is there anything else you would like us to know or any specific questions you have regarding acupuncture or your health? _____

By signing below, I acknowledge that the information provided in this form is accurate to the best of my knowledge. I understand that this information will be used to assist in my acupuncture treatment.

Signature: _____ Date: _____
Thank you for taking the time to fill out this intake form. We look forward to helping you with your acupuncture needs. If you have any questions, please feel free to ask.