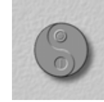
INTAKE FORM

Newton Center Acupuncture
72 Langley Rd. S-23 Newton Center, Ma. 02459
617-558-3308



Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Thank you.

I. **Please tell us about yourself:**				
Name:			Age:	
Address:			Zip:	
Phone: (home) __ __ __ / __ __ __ – __ __ __ __		(work) __ __ __ / __ __ __ – __ __ __ __		
Place of Birth:		Occupation:		
Marital Status (*circle one*):	Single	Married	Divorced	Partnership
Children?	Please list their ages:			
Height:	Weight:	Blood Pressure (approx.):		

II. ***Please tell us about your main complain and medical history:***

1. When did your *main complain* begin?

2. Please describe your personal experience of this condition?

3. What makes this condition better or worse?

4. In what way and to what extent does it affect your daily activities?

5. Mark areas in which there are significant accompanying symptoms:

☐ I. Body temperature ☐ II. Sleep ☐ III. Energy
☐ IV. Memory and concentration ☐ V. Appetite, Digestion, Thirst ☐ VI. Urination
☐ VII. Elimination ☐ VIII. Affect (Mood)
☐ IX. Gynecology /Sexuality / Reproduction ☐ X. Headache, Eyes, Ears, Nose, Throat
☐ XII. Respiration ☐ XIII. Miscellaneous (body pain, nails, hair)

5. What would happen if your condition would change, in what way would you be different?

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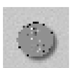
6. What areas tend to become vulnerable when tired or under stress?
7. Other related or apparently unrelated difficulties or problems:
8. Past medical history: (significant illnesses for which you have received medication, surgery, hospitalization. Please include date.)
9. Significant trauma (accidents, falls, etc.)
10. Allergies (seasonal, drugs, chemicals, food, etc.)
11. Birth history -your own- (prolonged labor, premature birth, etc.)
12. Family (parents, grandparents, siblings) medical history :
13. Any serious or communicable diseases (HIV, hepatitis, epilepsy, etc.)
14. Specify chronic diseases and medications taken for them (Cardiovascular; Diabetes; Psychological disorders; Thyroid)

Diseases	**Medications**

15. Do you take any vitamins, herbs, nutritional supplements, other? Please list:



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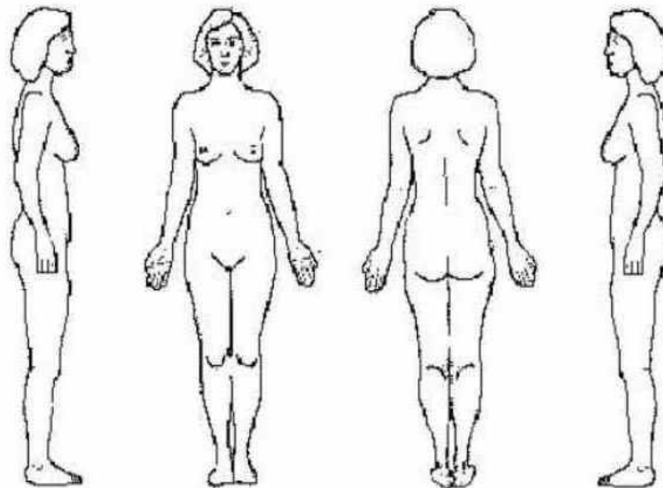
III. Please tell us about your life style:
1. Do you exercise? Please describe:
2. Please describe your typical daily food intake, in the last few days:

Breakfast	
Lunch	
Dinner	
Snacks between meals	
Cravings	

8. Coffee, alcohol, recreational drugs, tobacco; how often and how much?

IV. Please mark down sensitive or painful areas



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