Acupuncture Intake Form

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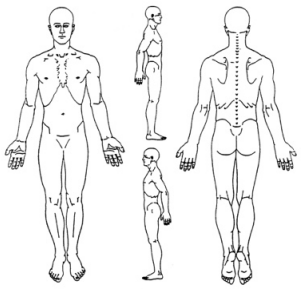
Patient Name:_____Patient#:_____Date:_____Time: _____Visit#:_____
[ ] Initial, [ ] Follow Up, [ ] Re-Evaluation ([ ] monthly, [ ] change in conditions, [ ] failure to respond, [ ] new complaint or injury)

SUBJECTIVE

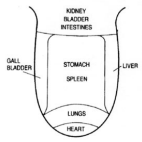
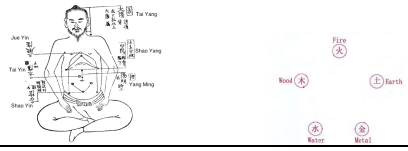
	Severity
Complaint #1 Complaint #2 New/Other Complaint	
Since _____, it has [ ] improved, [ ] deteriorated, [ ] no change	
Nature of pain: [ ] shooting, [ ] throbbing, [ ] numbness, [ ] sharp, [ ] tingling, [ ] burning, [ ] dull, [ ] aching, [ ] stiffness, [ ] cramps, [ ] swelling, [ ] heaviness, [ ] tension/tightness Activity/movement that is painful: [ ] sitting, [ ] bending, [ ] standing, [ ] lying down, [ ] walking, [ ] lifting Pain interfere with your: [ ] sleeping, [ ] walking, [ ] exercising, [ ] dressing, [ ] eating, [ ] medicines	
Other Report	



Pain location (circle above) / level 1-10 (10 is the worst)

OBJECTIVE H -hypertonic muscle / W-weakness / T-tenderness / R-right / L-left / M-midline

	Cervical		Shoulder		Ribs		Elbow		Quadriceps	Knee
	Thoracic		Trapezius		Abdomen		Wrist		Hamstrings	Ankle
	Lumbar		Chest		Biceps		Hand		Sciatic	Foot
	Sacroiliac		Pectorals		Triceps		Fingers		Hips/pelvis	Toes

Pulse	Tongue	Abdomen
		

ASSESSMENT

Diagnosis	[ ] Continuation with no change [ ] Improvement [ ] New
Prognosis	[ ] Excellent, uncomplicated, continued improvement expected, pem1anent residuals not expected [ ] Good, uncomplicated, continued improvement anticipated, permanent residuals possible [ ] Fair, complicated, continuing improvement doubtful, permanent residuals probable [ ] Unfavorable, complicated, continuing improvement doubtful. permanent residuals expected, supportive care medically necessary

PLAN Reduce symptoms, increase functional capacity and return to normal occupational & activities of daily living

[ ] Acute Phase.....stabilize condition, control inflammation, reduce spasm and pain (TX:2x wk/4-6wks)
[ ] Subacute Phase.....as above + supplement repair of tissues, joints to increase pain-free ROM (TX: 1x wk/6-8 wks)
[ ] Rehab Phase.....as above + passive & active cure to increase ROM strength, coordination, endurance, and work capacity (TX: lx wk/8-10 wks)
[ ] Exacerbation chronic case....support, stabilize, and recondition patient to previous status: required individual assessment (TX: 2x 1x mo/6 mos)

Treatment Acupuncture Point Prescription (T-Master Tung, R-right, L-Left, B-Bilateral) with multiple reinsertions & manual stimulation

Unit 1:

Unit 2:

Unit 3:

Unit 4:

Needle Count (inserted/removed): _____/_____ Total Patient Contact Time: _____

Post Treatment Patient's Statement

Locution of pain	Severity	ROM has improved:
Other changes observed:		

Post Treatment Practitioner's Statement

Today's response was [ ] excellent, [ ] good, [ ] fair, [ ] poor
Patient progress is [ ] improving drastically, [ ] slowly but steadily,
[ ] execration of symptoms with DAL, [ ] no change/ worse
Patient being seen [ ] 2x/week, [ ] 1x/week, [ ] 2x/month, [ ] 1x/month

Practitioner Signature: _____ **Date:** _____

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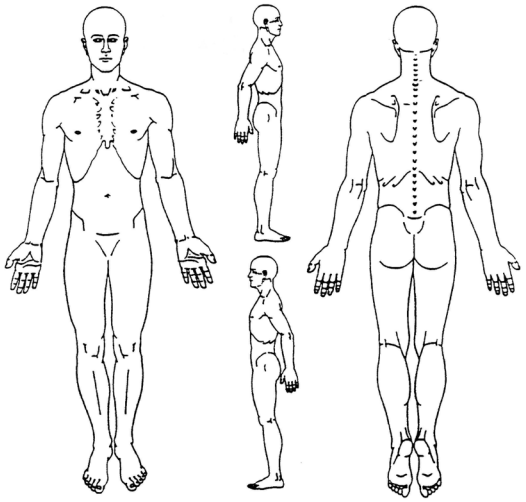

Circle location of Pain. Pain level 1-10 (10 is the worst).

SLEEP

#..... hours per night
◯ Difficulty falling asleep
◯ Disturbing dreams
◯ Restless sleep
◯ Waking without rested
◯ Other: ……..

◯ Wake up
……. times per night
at …….. am
◯ Go back to sleep take
…….. minutes

DIGESTION

◯ Indigestion
◯ Gas/Bloating
◯ Stomach Pain
◯ Gallbladder Problem
◯ Poor Appetite
◯ Excessive Hunger

◯ Nausea
◯ Vomiting
◯ Acid Reflux
◯ Hernia
◯ Hemorrhoids
◯ Other: ……..

Bowel Movement……..Times……..Day(s)

Mark X to indicate the typical condition of the stools

Loose — Formed — Hard

Diarrhea — Constipation

EMOTIONS

◯ Depression
◯ Difficulty Focusing
◯ Dizziness
◯ Easily Startled
◯ Excessive Worries
◯ Excessive Anger
◯ Other: ……..

◯ Excessive Fear
◯ Affected Sleep
◯ Weight Change
◯ Nervousness
◯ Irritability
◯ Overwhelmed by Life

If Applicable

Skin
◯ Skin Boils, Rashes
◯ Dry, Itch Skin
◯ Easily Bruised

Sensory Organs
◯ Blurred Vision
◯ Tinnitus
◯ Loss of Hearing
◯ Sinus Problem
◯ Gum Troubles

Urinary Organs
◯ Painful Urination
◯ Frequent Urination
◯ Inability to hold Urine
◯ Kidney Infection
◯ Kidney Stone

Andrological
◯ Erectile Difficulties
◯ Penal Discharges
◯ Prostate Issues

Gynecological
◯ Bleeding b/t Periods
◯ Clots in Menses
◯ Excessive Flow
◯ Scanty Flow
◯ Menstrual Pain
◯ Irregular Cycles
◯ PMS
◯ Menopausal Symptoms
◯ Infertility
◯ Previous Miscarriage
◯ Hysterectomy

ENERGY

Low — High

◯ Fatigue/Tiredness
◯ Heaviness
◯ Weakness
◯ Shortness of Breath
◯ Heart Palpitations
◯ High/Low BP

◯ Headaches
◯ Cold Hands/Feet
◯ Body Chills
◯ Sensitive to Weather
◯ Getting Sick Easily
◯ Other: ……..

Practitioner Signature: _____

Date: _____