Turning Point Acupuncture
1404 Starling Drive, Henrico, VA 23229
(804) 510-8507

Patient Intake Form

Date:_____

Name:_____
Last First Middle

Date of birth:_____

Street Address/apt #:_____

City/County:_____ State:_____ Zip:_____

Primary phone:_____ Secondary:_____

Email:_____

Relationship status: (circle) married domestic partner single widowed divorced

Gender: male female other

Emergency contact:_____ Phone:_____

If under the age of 18, a parent/guardian's name is required.

Father's name:_____ Phone:_____

Mother's name:_____ Phone:_____

Guardian's name:_____ Phone:_____

Who referred you to us?_____

Who is your primary health care provider?_____

Primary provider phone number:_____

Current Health Concerns

What would you like us to help you with?_____

How long ago did this begin?_____

Have you been given a diagnosis? If so, what?_____

Who diagnosed you?_____ Type of provider:_____

What kind of treatments have you tried?_____

_____

What has been helpful?_____

Are you currently receiving any treatment?_____

Personal Health and Wellness

Height: _____ Weight:_____

Major Illnesses:_____

Surgeries:_____

Significant trauma (car accidents, falls, etc):_____

_____

Chronic conditions:_____

Prescription medications, over the counter medications, vitamins, and herbs taken within past 3 months:

_____

_____

Personal birth history: (prolonged labor, forceps, cesarean, etc)_____

Childhood health:_____

Location of upbringing:_____

Occupation:_____ Stress level:_____

Overall quality of life (circle): excellent good fair poor

Favorite time of year:_____ Least favorite time of year:_____

Do you easily feel (circle): hot cold

Hobbies and recreational activites:_____

How frequently do you exercise? (# times/week)_____

What kind of exercise:_____

How much/when do you sleep?_____

Are you often tired or easily fatigued?_____

Average daily diet: BF:_____

LU/Snack_____

DN/Dessert_____

Do you frequently skip meals?_____

Special dietary requirements? (vegetarian or vegan, gluten-free, etc):_____

Do you use alcohol? yes no If yes, # of times/wk:_____

Do use tobacco products? yes no If yes, amount/day:_____

Former smoker? yes no If yes, yrs use:_____ & Quit date:_____

Do you drink caffeine? yes no If yes, # times/day:_____

Non-prescription drug use? yes no If yes, type:_____

Do you have any allergies?: (food, seasonal, animal, etc)_____

Allergy symptoms:_____

Family Medical History

Chronic conditions (heart disease, cancer, diabetes, etc)/cause of death in close family (parents, grandparents, siblings, aunts/uncles)

Condition/cause of death:_____relationship:_____

Condition/cause of death:_____relationship:_____

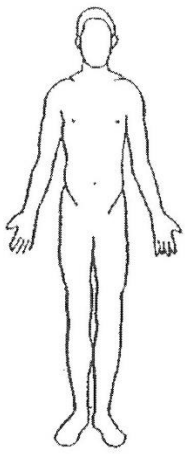
Condition/cause of death:_____relationship:_____

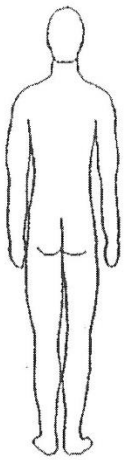
Condition/cause of death:_____relationship:_____

Condition/cause of death:_____relationship:_____

Pain Questionnaire

Please circle areas of pain and injury.
Please be prepared to describe the type and quality of pain.





Current pain level: (0-10)_____ Average pain level: (0-10)_____

Worst time of day:_____ Best time:_____

Activities that aggravate the pain:_____

Activities that improve the pain:_____