ACUPUNCTURE INTAKE FORM

Name_____Date_____Age_____

Main Complaint_____

Family History_____

1. Sleep Habits
   Difficulty Falling Asleep ( ) yes ( )No
   Difficulty Staying Asleep ( ) yes ( )No
2. Urine
   How often ( ) frequent ( ) scanty
   Color ( ) clear ( ) yellow ( ) dark yellow
3. Bowel Movements
   How often _____
   Constipation ( ) yes ( ) no
   Diarrhea ( ) yes ( ) no
   Odor ( ) yes ( ) no
   Loose ( ) yes ( ) no
   Color ( ) black ( ) brown ( ) mucous
   Flatulence ( ) yes ( ) no
   Chills/Fever ( ) yes ( ) no
   Perspiration ( ) yes ( ) no
   Pain Location _____
   Diet cravings ( ) Sweet ( ) Salt ( ) Sour
   ( ) Pepper ( ) Spicy
4. Menses
   Clotting ( ) yes ( ) no
   Pain ( ) yes ( ) no
   Length ( ) normal ( ) abnormal
   Duration ( ) normal ( ) abnormal
   Color ( ) normal ( ) abnormal
   Flow ( ) scanty ( ) heavy ( ) normal
   Onset Age: _____
   Birth Control ( ) yes ( ) no Age: _____
5. Hormone Replacement Therapy
   ( ) yes ( ) no
   Discharge ( ) yes ( ) no Color: _____

Authorization

I hereby authorize the Doctor to examine and treat any condition she deems appropriate through the use of Meridian Healing. I give authority for all these procedures performed. I also agree that I am responsible for all bills incurred at the office.

_____

Patient Signature Date

_____

Guardian Signature Date

CHIROPRACTIC In-Motion