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Acupuncture, Alexander Technique & Wellness in Chapel Hill, NC

Support for the Whole Being

Intake Form

Information provided on this form is confidential. Please fill it out as much as is comfortable for you to enable me to best support your healing and wellbeing. Thank you!

PLEASE PRINT

Today's Date ____/____/____ Name _____

Date of Birth ____/____/____ Age: _____ Email_____

Address_____

Phone #_____ Whom may I thank for referring you?_____

Emergency Contact:

Name _____

Relationship _____ Phone #_____

What are the primary concerns for which you are seeking support?

1._____

2._____

3._____

What support or treatment(s) have you sought for any of the above?

_____

What brings you relief or makes you feel more yourself?(activities, rest, heat, cold, sleeping, crying, etc.)

_____

What makes things worse? (fatigue, stress, certain foods or activities, or times of day, heat, cold, etc.)

_____

Date____/____/____ **Last Name**_____ **DOB**____/____/____

What is your experience, if any, with Chinese medicine, Acupuncture, Alexander Technique, or Breathing Coordination?

What helps you to feel most balanced? Or, when do you feel at your healthiest and most yourself?

What messages are you aware of that your body communicates to you? Do any of these messages repeat? Have you experienced change due to these messages?

Occupation: _____ Relationship Status: _____

Children? _____ Pets? _____ Other Dependents? _____

How would you rate your stress level: very low / low / moderate / high / very high / extreme

Typical Diet: (*Please list typical daily foods and beverages where applicable*):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Any food allergies or diet restrictions? _____

Caffeine? Yes / No Alcohol? Yes / No Tobacco? Yes / No Other substance? Yes/No

How is your energy level ?_____When is it lowest ?_____ Highest?_____

Typical bedtime? _____ Typical waking time?_____ Average hours sleep? _____

What's your favorite exercise or movement:_____

How often do you get to that in a typical week? _____

Typical Bowel Movements: How often? _____ Consistency? _____

Date____/____/____ **Last Name**_____ **DOB**____/____/____

Are you pregnant or trying to get pregnant? Yes/ No/ Maybe

Age at first period? _____ Age at last period/menopause?_____

Typical days of menstrual cycle: (from first day of menses until last day before next menses): _____

How many days do you typically bleed during menses? _____ Color of blood? _____

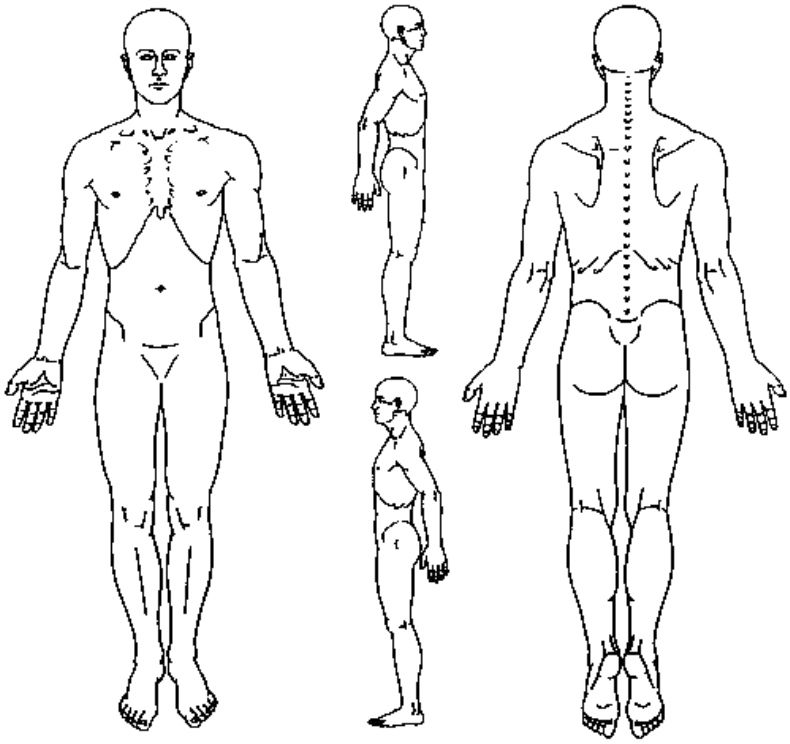
How many tampons/pads per day? _____ (or ounces of blood if menstrual cup)

Do you have (circle all that apply):
PMS, painful menses, irregular menses, breakthrough bleeding/spotting, clots during menses, IUD, peri or menopausal symptoms, vaginal discharge, vaginal dryness, other: _____

What medications and supplements are you currently taking?
(Please list and include kind, dose, method and frequency. Please also include herbal or home remedies, and over-the-counter medications.)

If you are experiencing pain, please mark all areas of pain on the diagram below with:

A= aching	B= burning	P= pins and needles
N=numbness	S= stabbing pain	O= other type of sensation



Date____/____/____ **Last Name**_____ **DOB**____/____/____

Please check (✓) if you sometimes experience and use a plus sign (**+**) if you frequently experience:

GENERAL		**RESPIRATORY**		**GENITO-URINARY**	
Fevers		Frequent Colds		Frequent Urination	
Chills		Nose Bleeds		Dark Urine	
Cravings		Sinus Congestion		Cloudy Urine	
Feel cold easily		Allergies		Scanty Urine	
Feel warm easily		Chest Congestion		UTIs	
Excessive Thirst		Chest Tightness		Blood in Urine	
Excessive Hunger		Shortness of Breath		Kidney Stones	
Weight loss		Phlegm (color_____)		Inability to hold Urine	
Weight gain		Cough (Wet / Dry)		**DIGESTION**	
Muscle weakness		Coughing Blood		Poor Appetite	
Numbness/Tingling		**EYES AND EARS**		Trouble Swallowing	
Loss of Balance		Itchy Eyes		Heartburn/Acid Reflux	
Vertigo or Dizziness		Watery Eyes		Pain/Cramps	
Tendonitis		Dry Eyes		Nausea	
Fractured Bones		Swollen eyes		Vomiting	
Arthritis		Red Eyes		Bloating	
Bone Pain		Blurred Vision		Gas	
Swollen Joints		Spots in Front of Eyes		Bad breath	
Palpitations		Hearing Difficulty		Strong Smelling Stool	
Pacemaker		Ringing in Ears		Diarrhea	
HIV		Earaches/ Ear Infection		Constipation	
Hepatitis		**HEAD / NECK**		Mucous in Stool	
Seizures		Headaches		Black/Bloody Stool	
Metal or Other Implants		Migraines		Undigested Food in Stools	
SKIN		Jaw Pain		Loose Stool	
Acne		Teeth Grinding		Sticky Stool	
Rashes		Swollen Glands		Hemorrhoids	
Dry Skin		Sore Throat		**MENTAL / EMOTIONAL**	
Redness of Skin		Sore/Bleeding Gums		Mood Swings	
Itching		Hoarseness		Anxiety	
Hair Loss		Goiter		Depression	
Bleed/Bruise easily		**SEXUAL/REPRODUCTIVE**		Difficultly Concentrating	
Slow healing ulcerations		Low Libido		Poor Memory	
Weak or ridged nails		High Libido		Easily Irritated	
Sweating hands & feet		Current STD		Ruminating	
Cold hands & feet		Infertility		Sadness	
Swelling		Premature Ejaculation		Emotional Highs	
Sweat Easily		Erectile Dysfunction		Easily Alarmed	
Hot Flashes		Enlarged Prostate		PTSD	
Night Sweats		Breast Tenderness		Nightmares	
		Cysts/Fibroids/Polyps		Angry Outbursts	

Is there anything else you would like me to know as we begin to work together?