Trina Lion, L.Ac.
Acupuncture Intake Form

Today's Date _____
Name _____
Age _____ (please circle one) Male / Female
Mailing Address _____
Email Address _____ Phone _____ (Daytime) _____ (Evening)
Preferred Contact (circle one): Email / Phone
Emergency Contact: Name _____ Relationship: _____
Mailing Address: _____
Email Address _____ Phone _____ (Daytime) _____ (Evening)
How did you hear about this clinic? _____
Why are you seeking treatment? _____
How long has this condition bothered you?
When did it start? _____
What does this prevent you from doing? _____
On a scale of 0 to 10, how does it feel? _____

0 10

0 = no discomfort 10 = worst discomfort

What makes it better? _____ Worse? _____
[Hint: Diet, weather, exercises, and certain situations may affect your symptom.]
Have you received any other treatment for this condition?
How is your energy level? _____ Appetite? _____ Ability to focus? _____ Sleep? _____

Have you or your child experienced any of the following conditions (please circle):

Addictions	Elimination concerns	Nightmares
Allergies	Emotional concerns	Numbness or tingling
Anemia	Epilepsy	Palpitations
Asthma	Fatigue	Poor circulation
Blood pressure concerns (low or high)	Gout	Polio
	Gynecological concerns	Reproductive concerns
Cancer	Headaches	Seizure
Chest pain	Heart disease	Shingles
Chicken pox	Hepatitis (A, B, C)	Shortness of breath
Cough	HIV	Stroke
Dental concerns	Insomnia	Substance use
Dermatological concerns	Laryngitis	Tuberculosis
Diabetes	Memory loss	Thyroid
Digestive concerns	Multiple Sclerosis	Vision concerns
Eating disorders	Muscle pain / strain	Weight loss / Gain

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