Stepping Stone Acupuncture Intake Form

(All information is confidential; refer to privacy practices document)

Name_____ Date_____

Gender: F M NB T Pronoun(s) _____

Date of Birth _____ Age _____

Address_____

City_____ State _____ Zip _____

Number: (Cell/work/home) _____

Secondary number (Cell/work/home) _____

- ☐ I consent to receive phone calls/voice messages from Stepping Stone Acupuncture LLC
- ☐ I consent to receive text messages from Stepping Stone Acupuncture LLC
- ☐ I **do not** consent to receive phone calls/voice messages or text messages from Stepping Stone Acupuncture LLC

Email _____

Employer _____Occupation_____

Emergency contact name _____

Emergency contact number _____

Primary Care Physician _____

How did you hear about Stepping Stone Acupuncture?

_____

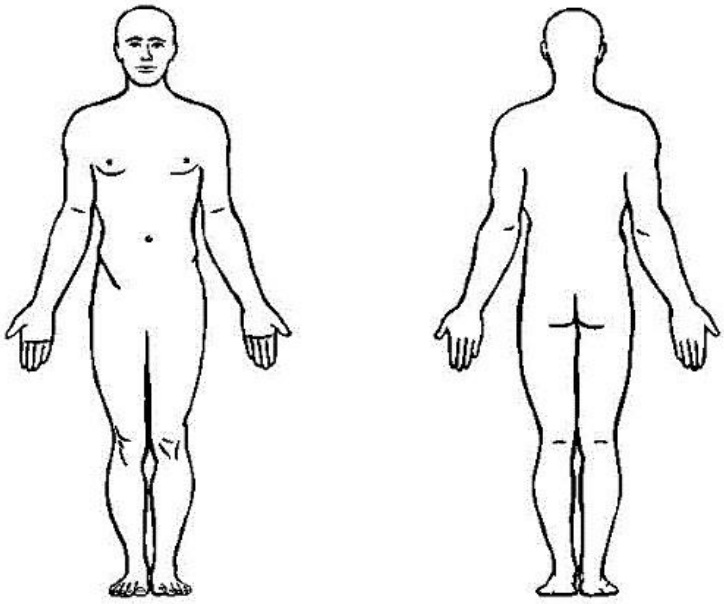
Medical History Form

Name _____ Date _____

Goals: What would you like to achieve with acupuncture/Chinese medicine?

Symptoms/Areas of concern:

Pain



On a scale of 1-10 (1=no pain, 10=extreme pain) rate:

Pain right now: _____

Pain most days: _____

Please indicate where the pain is on the illustration

XXX= sharp/stabbing

PPP=pins/needles

DDD= dull/achy

NNN= numbness

Reproductive

Please answer the following questions *as they apply to you*:

1. Are you pregnant now? Yes No Unsure

2. Age: First period _____ Menopause (if applicable) _____

3. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____

4. Any History of an Abnormal Pap Smear? Yes No

If yes, what / when? _____

5. Is your menses cycle regular? Yes No

a) Average number of days of flow _____

b) The flow is: Normal Heavy Light

c) The color is: Normal Dark Purple Light Brown Brown

6. Do you have the following menstruation related signs/symptoms?

Difficulty with Orgasm Cramps PMS Nausea

Pain with Intercourse Heavy Vaginal Discharge Blood Clots

PCOS Endometriosis High libido Low libido

Bleeding between Periods Breast Distention Other:_____

7. Do you have any bothersome urinary symptoms? Yes No If yes, describe: _____

8. Circle all that apply:

Erectile dysfunction Difficulty with orgasm Impotence

Pain/swelling of testis Feeling of coldness or numbness of genitals

Premature ejaculation Frequent urination Other: _____

9. Do you get up at night to urinate? Yes No

How often? _____

10. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)

_____

11. Have you sought Medical intervention for these problems? If so, when?

_____

12. What treatments have you tried for these problems and how successful have they been?

_____

Transgender Health *(if applicable)*

Sex assigned at birth: F M I

Are you taking any gender affirming hormones? Y N

Have you had gender affirming surgery? Y N

Are there other concerns regarding transgender health that I should know to provide better care to you?

Medical History

1. Please circle all that apply

High Cholesterol Diabetes High blood pressure HIV/AIDS

Thyroid disorder Seizures Hepatitis Cancer: _____

Anxiety Depression Other(s): _____

2. Have you unintentionally lost/gained a significant amount of weight in the past 6 months? Yes No

3. Surgical History

_____ Date _____

_____ Date _____

_____ Date _____

Medications/supplements:

Allergies (medications, foods, chemicals, environmental):

Family Medical History

Condition	**Relationship(s)**
Heart Disease	
Cancer	
Hypertension	
Stroke	
Asthma	
Migraines	
Depression/Anxiety	

Other mental illness:	
Substance abuse	
Osteoporosis	
Diabetes	
Glaucoma	
Other:	

Nutrition

1. Do you follow a particular diet? Yes No

If yes, how would you describe your diet? (Vegan, Low Carb, Gluten free etc.)

_____

2. Do you avoid any foods due to religious belief? If yes, please list:

_____

3. What do you eat on a "typical" day?

_____

a) Breakfast

_____

b) Lunch

_____

c) Dinner

_____

d) Snacks

_____

e) Foods you tend to crave: _____

f) Foods you dislike: _____

Lifestyle

1. How much per day do you use of the following?

a) Coffee, tea, soft drinks: _____

b) Alcohol: _____

c) Cigarettes, cigars, other tobacco:
_____

d) Other drugs: _____

2. Have you ever had a problem with alcohol or alcoholism? Yes No

3. Have you ever had a problem with dependency on other drugs? Yes No

4. If yes which and when?

_____

5. Do you have a known history of any exposure to toxic substances? Yes No

If so, please list which and when you first noticed symptoms?

_____

6. In the past year, how many days have been significantly affected by your health? _____

7. How many days did you feel generally poor? _____

8. How many times were you in the hospital? _____

9. Please describe your current physical activity:

Hours per week: _____ Activities: _____ [ ] No activity

10. How many hours of sleep do you usually get per night? _____

11. Do you awake feeling rested? Yes No

12. Do you feel you sleep well at night? Yes No

13. Who would you describe as your source of primary social support? (relationship to you) _____

Please provide any more information that is important for the practitioner to know:

_____

_____

_____