

Finish Line Acupuncture
Initial Acupuncture Health Assessment

Note: Information provided on this form is confidential. Please take time to thoughtfully and honestly answer these questions in order to better your healing process.

Name: _____ Date of Birth: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Secondary #: _____

Email Address: _____

A 24-hour cancellation notification is required. You may be charged for your appointment for a cancellation made with less than 24 hours' notice.

Please initial that you have read and understand the above statements: _____

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Have you ever received Acupuncture before? Yes / No

What health concern(s) bring you in today? _____

Have you been examined by a medical doctor for any of these health concerns? Yes / No

If yes, what was your medical diagnosis: _____

List any medications/supplements you are currently taking: _____

List any known allergies: _____

List any significant traumas (accidents, falls, injuries): _____

List any significant surgeries you have had: _____

Do you have any type of bleeding disorder? Yes / No

Do you have a pacemaker? Yes / No



Have you ever been diagnosed with any of the following? Circle all that apply:

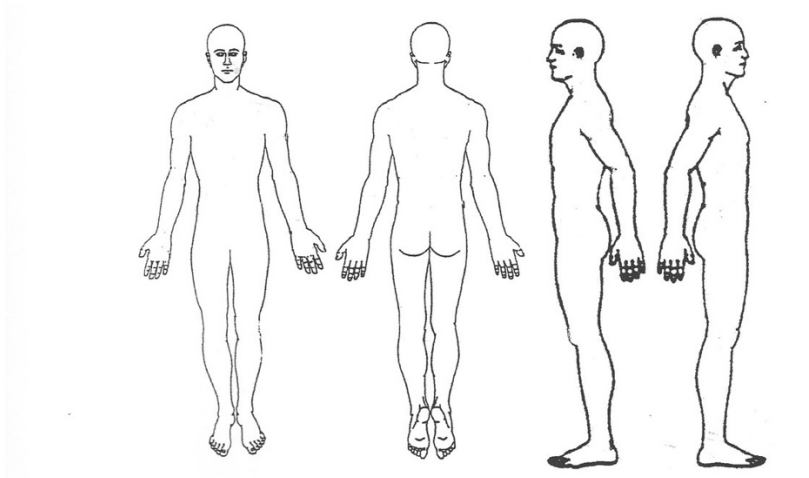
Diabetes
High Blood Pressure
Low Blood Pressure
Anemia

Blood Clots
Heart Attack
Stroke
Seizures

Asthma
Tuberculosis
HIV/AIDS
Hepatitis B

Family Medical History (parents, siblings, grandparents): _____

If you have any aches or pains, mark the areas where you experience pain:



List what you typically eat during the day: Gluten free Vegetarian Vegan Other

Breakfast: _____

Lunch: _____

Afternoon snacking: _____

Dinner: _____

Evening snacking: _____

Foods you avoid/minimize: _____

How many ounces of water do you drink in a day? _____

How much caffeine do you consume daily? _____

How much alcohol do you consume in a week? _____

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

How would you rate your energy levels? (Poor) 1 2 3 4 5 6 7 8 9 10 (High)

Women's Health History

Menstruation

Age when menses began: _____

Menstruation lasts _____ days

I have a:

Regular cycle of _____ days

Irregular cycle of _____ to _____ days

During your period, do you experience any:

Dysmenorrhea (Cramps)

Fatigue

Breast tenderness

Sleep Disturbance

Other: _____

During your period, the flow is:

Light/spotting on days _____

Medium on days _____

Heavy on days _____

What color is the blood?

Light Red on days _____

Bright Red on days _____

Dark Red on days _____

Brown on days _____

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Reproductive History

Are you currently using birth control? Y / N

Have you recently stopped or started birth control? Y / N

If so, when? _____

Are you trying to conceive? Y / N

Have you given birth in the last year? Y / N

Are you currently lactating? Y / N

Have you had any:

High-risk pregnancies

Difficult labor/deliveries

Postpartum depression/concerns

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Menopause

Are you perimenopausal? Y / N

Do you currently experience any:

Night sweats/Cold flashes

Hot flashes (daytime)

Sleep Disturbance

Spotting

Other: _____

Are you postmenopausal? Y / N

What year was your last period? _____

Thank you for choosing Finish Line Acupuncture!

