LONG ISLAND SPINE
REHABILITATION MEDICINE

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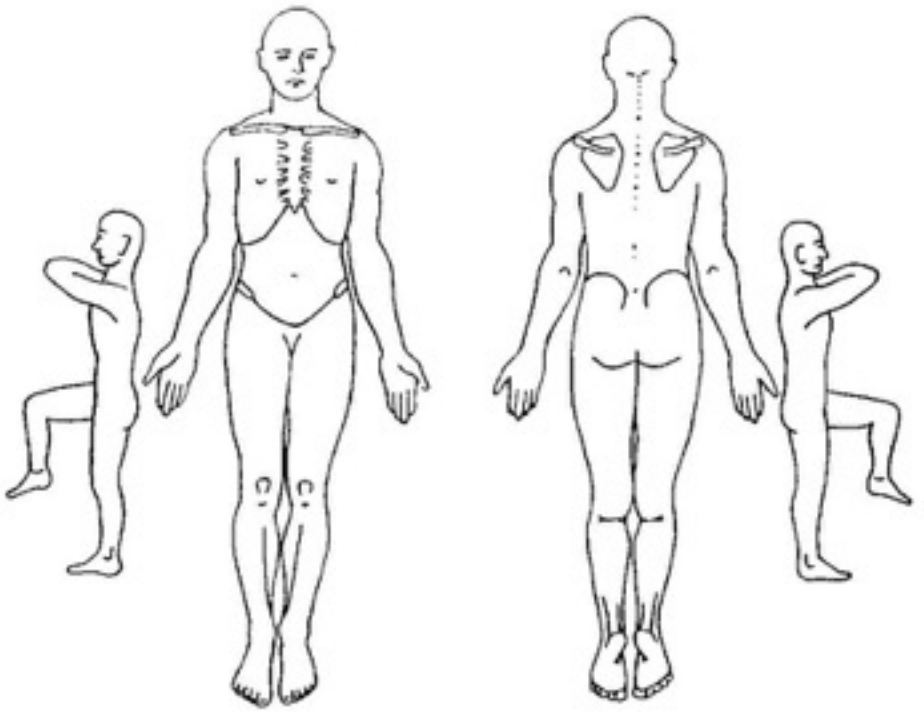
Acupuncture Initial Intake Form

Patient Name: _____ **Date:** _____

Date of birth: _____

Reason for Visit	Date of onset	Intensity (1-10)	Frequency

Please mark in the area(s) of pain with an "X":



Describe the condition:

Quality of pain (mark all that apply):

Sharp/Stabbing	Dull/Aching	Numb/Pins and Needles

Better or worse with the following?

Heat	Cold	Rest	Activity	Other

History:

Family:	
Childhood:	
Adolescence:	

Adulthood:	
Sleep:	
Digestion:	
Urination:	
Stress:	
Any heart conditions, pacemaker, history of seizure or metal implants in the body?	
Current medications and supplements:	

Women:

When did your menstruation start?	
Is/was it regular?	
Quality of the blood:	
Are you pregnant?	
Have you had any children? If so, how many?	
Trouble conceiving?	
When did you start menopause?	