Marys River Healing Arts
Gretchen Landis, L.Ac., L.M.T. #5151

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Acupuncture Intake Form

Please print: **Information provided on this form is confidential.**

Full Legal Name: ____

Preferred Name: ____

Birth Date (mm/dd/yyyy) ____________________ Pronouns ___________________________

Address: ____

City/State/Zip: ____

Cell Phone: (_______) ___________________ Home Phone: (_______) ___________________

Work Phone : (_______) ___________________

Email Address: ____

Would you like to join our email list? We send out small updates once or twice a year: ________

How do you prefer to receive communications, such as reminders for upcoming appointments?

Call: Home- ☐ Work- ☐ Cell- ☐ / ☐ Text / ☐ Email

☐ I do not wish to receive reminders for upcoming appointments. I understand that any missed visit will be subject to a missed visit fee.

Emergency Contacts:

Primary:

Name: ____ Relationship: __________________

Phone: (_______) ____________________

Secondary:

Name: ____ Relationship: __________________

Phone: (_______) ____________________

If we need to reach you quickly, such as for an emergency on our end, what is the best way to do so?

____

How did you hear about us?

____

Is this your first experience with acupuncture?

____

How do you feel about acupuncture?

____

What is your reason for this visit?

____

____

When did your symptoms first begin?

____

Are symptoms constant or intermittent?

____

Symptoms are relieved by:

____

Symptoms are worsened by:

____

Have you tried other treatments or received a medical diagnosis for this?

____

What medications are you taking?

____

For what condition(s)?

____

Other diagnoses or health issues affecting you:

____

Any other serious diseases, injuries, or hospitalizations and when they happened:

____

Please list your current medications and supplements, when you started taking them, and the reason for them:

____

Do you have any allergies or sensitivities to medications, foods, environmental irritants, or other substances?

Please list significant family illnesses:

Grandparents: ____

Father: ____

Mother: ____

Siblings: ____

Tobacco use: Smoke ○ Chew ○ Vape ○ Other ○

Please explain if necessary: ____

Alcohol use: ____

Other drug use:

____

Do you have or think you may have any addictions?

____

Are you physically active on a regular basis? What type of activity and how often?

___

How is your energy?

___

What time of day is your energy lowest? ___________________

Highest?

Do you fatigue easily?

___

How much does stress affect your life?

___

What are the current major stressors in your life?

___

What is your job satisfaction level?

___

How many hours per week do you work?

___

What is your favorite recreational activity?

___

What is the major source of joy in your life?

___

What are your goals for your health?

___

On the pictures below, please indicate all areas of pain, numbness or discomfort: