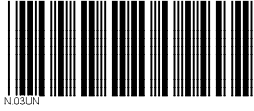


ST. JOHN'S HOSPITAL  
800 E. Carpenter Street  
Springfield, Illinois 62769



Please print and complete ALL questions.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone-Eve: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Primary health care provider: \_\_\_\_\_

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Contact #: \_\_\_\_\_

Have you ever received an acupuncture or massage treatment?  Yes  No *If Yes, frequency & date of last treatment or problems:* \_\_\_\_\_

Main complaint(s) or purpose for visit:

I: \_\_\_\_\_

II: \_\_\_\_\_

III: \_\_\_\_\_

What results do you expect from your treatment sessions? \_\_\_\_\_

\_\_\_\_\_

Are you currently being treated by other medical practitioners?  Yes  No *If Yes, please explain:* \_\_\_\_\_

\_\_\_\_\_

*Acupuncture/massage may bring up emotional issues, and is often used in conjunction with psychotherapy to enhance the process.*

Are you currently seeing a psychotherapist or are you attending regular support group meetings?

Yes  No *If Yes, please explain:* \_\_\_\_\_

\_\_\_\_\_

List stress reduction and exercise activities. Include frequency: \_\_\_\_\_

\_\_\_\_\_

List current medications, including aspirin, ibuprofen, herbs or supplements, etc.: \_\_\_\_\_

\_\_\_\_\_

List previous surgeries and/or physical injuries (include year and treatment): \_\_\_\_\_

\_\_\_\_\_

## ACUPUNCTURE INTAKE - Center for Living

Page 2 Client Name: \_\_\_\_\_

**SKIN**

- allergies \_\_\_\_\_
- rashes \_\_\_\_\_
- athletes' foot \_\_\_\_\_
- warts \_\_\_\_\_
- other \_\_\_\_\_

**DIGESTIVE**

- constipation \_\_\_\_\_
- gas/bloating \_\_\_\_\_
- diverticulitis \_\_\_\_\_
- irritable bowel syndrome \_\_\_\_\_
- other \_\_\_\_\_

**NERVOUS SYSTEM**

- herpes/shingles \_\_\_\_\_
- numbness/tingling \_\_\_\_\_
- chronic pain \_\_\_\_\_
- fatigue \_\_\_\_\_
- sleep disorders \_\_\_\_\_
- other \_\_\_\_\_

**OTHER**

- cancer/tumors \_\_\_\_\_
- diabetes \_\_\_\_\_
- eating disorders \_\_\_\_\_
- depression \_\_\_\_\_
- drug/alcohol addiction \_\_\_\_\_
- nicotine/caffeine addiction \_\_\_\_\_

**MUSCULO-SKELETAL**

- bone/joint disease \_\_\_\_\_
- tendonitis \_\_\_\_\_
- bursitis \_\_\_\_\_
- broken or fractured bones \_\_\_\_\_
- arthritis \_\_\_\_\_
- jaw pain/TMJ dysfunction \_\_\_\_\_
- sprains/strains \_\_\_\_\_
- low back, hip, leg pain \_\_\_\_\_
- neck, shoulder, arm pain \_\_\_\_\_
- headaches/head injuries \_\_\_\_\_
- spasms/cramps \_\_\_\_\_
- lupus \_\_\_\_\_
- other \_\_\_\_\_

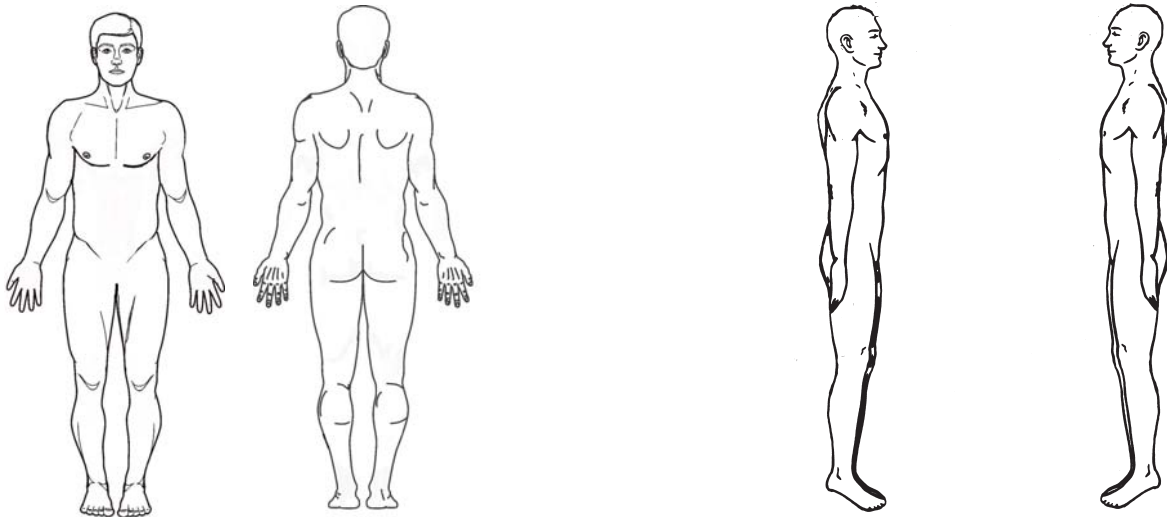
**CIRCULATORY**

- heart condition \_\_\_\_\_
- varicose veins \_\_\_\_\_
- blood clots \_\_\_\_\_
- high blood pressure \_\_\_\_\_
- low blood pressure \_\_\_\_\_
- lymphedema \_\_\_\_\_
- breathing difficulty \_\_\_\_\_
- sinus problems \_\_\_\_\_
- allergies \_\_\_\_\_
- other \_\_\_\_\_

**INFECTIOUS DISEASE**

- disease name(s): \_\_\_\_\_  
\_\_\_\_\_

*Please indicate the area of pain on the figures below:*



Patient Signature: \_\_\_\_\_