Acupuncture & Natural Health Solutions
Patient Intake Form

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name _____ Date _____

Date of Birth _____ Age _____ Sex _____

Address _____

City _____ State _____ Zip _____ Email _____

Phone: (H) _____ (W) _____ (Cell) _____

Is it ok to leave a message if you are unavailable? _____ Please star preferred number to call.

Marital Status _____ Significant Other? (Y) _____ (N) _____ No. of children _____

Emergency contact _____ Emergency phone _____ Relationship _____

Employer's Name & Address _____

Occupation _____ Number hours/week _____

Primary Physician Name & Phone _____

May I contact him/her to discuss your case? _____ Referred by _____

Purpose for coming: _____

Major concern only: _____
How would you classify the condition: ❑ Minor ❑ Involved ❑ Fairly severe & worsening ❑ Severe

What type of service do you desire: ❑ Temporary relief of symptoms/pain control ❑ Work on root cause & constitutional tendencies ❑ Balanced optimum health care ❑ Regular Maintenance ❑ Prevention

When did it begin _____ What caused it _____

Have you ever experienced this before _____ Please explain _____

Is it getting worse _____ Does it interfere with ❑ Work ❑ Sleep ❑ Daily Routine ❑ Exercise ❑ Home

Explain _____

Have you received other treatment? ❑ Yes ❑ No If yes, where _____

When _____ Diagnosis _____ Result _____

Secondary concerns _____

Severe allergies _____

Hospitalizations: When _____ Reason _____
When _____ Reason _____
When _____ Reason _____

Acupuncture & Natural Health Solutions
Patient Intake Form

Injuries: (Auto accidents, falls, etc.) _____
❑ Broken Bones ❑ Concussion or Head Injury ❑ Dislocations ❑ Sprains ❑ Loss of Consciousness

Are you experiencing physical, mental, or emotional stress at ❑ home ❑ work ❑ other _____
Explain _____

Personal History: Check if had in past, circle if currently have ❑ Cancer ❑ Pneumonia ❑ Anemia
❑ HIV/AIDS ❑ Diabetes ❑ Hepatitis ❑ Epilepsy/Seizures ❑ Nephritis ❑ Heart Disease ❑ Infection
❑ Hypertension ❑ Nervous Breakdown ❑ Food/Drug Poisoning ❑ TB ❑ Asthma/Hayfever ❑ Arthritis
❑Alcoholism ❑ Miscarriage ❑ Drug use ❑ Mental Disorder ❑ Genetic Disorder

Family History: Has your father or mother ever had: ❑ Cancer ❑ Stroke ❑ Diabetes ❑ Hypertension
❑ Kidney Disease ❑ Heart Disease ❑ Alcoholism ❑ Drug abuse ❑ Mental Disorder ❑Asthma

If you are in pain, please mark the exact location of your pain on the figures below. Describe the type, frequency, intensity and duration of your pain, as well as any activity which brings on or aggravates the pain. (i.e. abdominal sharp pain, every 30 seconds, for the last two hours when standing or sitting.)

_____

_____

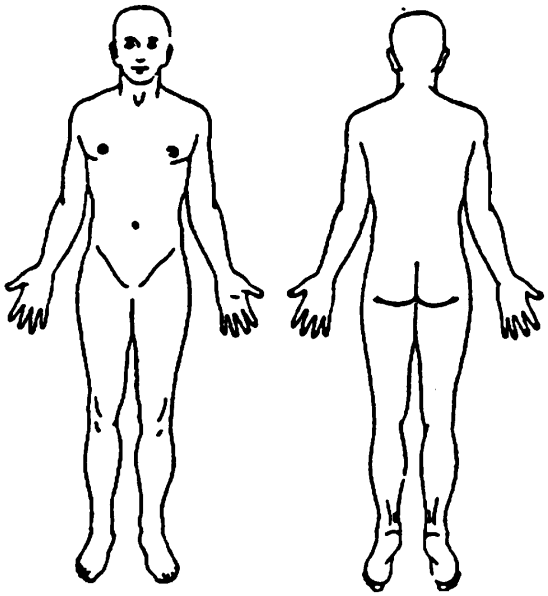
_____

_____

_____

_____

_____



Please indicate the use and frequency of the following?
❑ Tobacco ❑ Coffee/Black Tea ❑ Alcohol ❑ Exercise
❑ Recreational Drugs _____
_____
_____

List one adjective/word to describe your life _____
What did you have for your last breakfast, lunch, dinner, and snack? _____

_____

Current medications including vitamins, herbs, over the counter drugs, and pharmaceuticals _____

_____

_____

Anything else you think I should know _____
Email Opt-In for Updates, Newsletters & Promotions? ❑ Yes ❑ No Email:_____

Toni Eatros, AP 2731 2355 Vanderbilt Beach Rd, Suite 146, Naples, FL 34109 239-260-4566