Dr. Jeffrey Turre
Licensed Acupuncturist

Acupuncture and East Asian Medicine Intake Form

Name:_____ Date of Birth:_____
Phone:_____ Email:_____
Address:_____
Permission to leave messages regarding your care on □ Phone □ Email

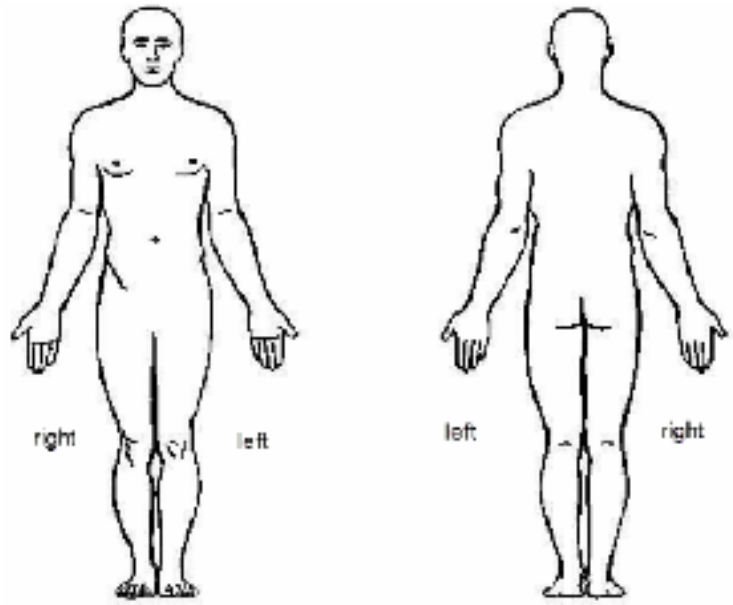
Have you had acupuncture before? Yes No If "yes", for what condition? _____

What are you interested in working on? _____
_____

What current treatment are you receiving for your concerns? _____
_____

(If your concerns include physical pain, please mark its quality and location below)

Location of pain: (please circle areas of pain or mark **X** for numbness/tingling)



Circle quality of pain:

Throbbing	Shooting
Stabbing	Sharp
Hot/ Burning	Aching
Heavy	Cramping

How often does this pain occur?

- Continuously
- 1 or 2 times a day
- Several times a day
- Several days a week
- Less than 4 times a month

How long have you had this pain?

- 3 months or less
- 12-24 months
- 3-6 months
- More than 24 months

If known, what is the cause of the pain? _____

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Health Concern Overview		
Check if you have, or have had, any symptoms to a significant degree and briefly explain in the space below.		
☐ Skin	☐ Chest/Heart	Changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestine/Bowel	☐ Energy Level
☐ Nose	☐ Stomach/Digestion	☐ Ability to sleep
☐ Throat	☐ Circulation	☐ Mood/Behavior
☐ Lungs	☐ Libido/Fertility	☐ Other:
☐ Muscles/Joints	☐ Pregnancy Related	☐ Other:

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Family History - please complete by placing an X in the appropriate box:

	Self	Mother	Father	Sibling	Grandparent
Diabetes					
Cancer/Tumor, Type:					
Seizures					
High Blood Pressure					
Substance Abuse					
Alcoholism					
Heart Disease					
Stroke					
Autoimmune Disorder, Type:					
Other:					

Allergies-please list known allergies and note severity (ex. medication, food, pollen)

_____

_____

Sleep
What time do you typically go to sleep? _____
How many hours do you typically sleep? _____
Do you wake often/ have difficulty staying asleep? _____
Do you wake feeling rested? _____

Stress Level (0= typically no stress, 10= often very stressed) _____

Major Hospitalizations/Health Emergencies
Year Operation or Illness

_____

_____

_____

_____

_____

_____

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Medications - please list any current medications you are taking (use back of page for more space)

Drug Name	Dosage	Frequency

Supplements and Herbs

Name	Brand/Source	Dosage	Frequency

Diet

Recent changes to diet? _____

Drink coffee/caffeine? (amount, frequency) _____

Do you have a spiritual practice you consider part of your health? _____
_____

What are your health goals? _____
_____

Please list any additional health/wellness related information you would like to share on the back of this form.

. . . . . .

To be completed by Acupuncturist

T:

P:

LU/LI	HT/SI
SP/ST	LV/GB
PC/SJ	KI/UB .

Assessment:

EAM Dx:

EAM Tx Principles:

Treatment Plan:

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Release of Information

All information provided herein is true and correct. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees and/or beneficiaries and other related persons. I have read and understood this release.

X_____ Date_____

Payment Policy

Payment of all services rendered is due at the time of service to Dr. Jeffrey Turre, LAc. I have read and understood this policy.

X_____ Date_____