SLO Family Acupuncture

2066 Chorro St ♦ San Luis Obispo, CA 93401
(805) 242-6852 ♦ www.slofamilyacupuncture.com

Name _____ Date _____

Address_____ City/State/Zip _____

Phone: H) _____ W) _____ C) _____

Email _____ Occupation_____

Emergency Contact: Name _____ Phone _____

Whom may we thank for your referral? _____

Gender _____ Pronouns (optional) _____ Legal Sex (for insurance): M F

Height _____ Weight _____ Date of Birth _____ Age ____

Relationship: Married Committed Relationship Divorced Widowed Single

Please take a moment to answer the following questions:

Have you had acupuncture before? ❑Yes ❑No *When/With Whom?* _____

What are your particular goals for this acupuncture session? _____

_____

Additional Health Concerns: _____

_____

How would you describe your current state of health? _____

What makes you feel better? _____

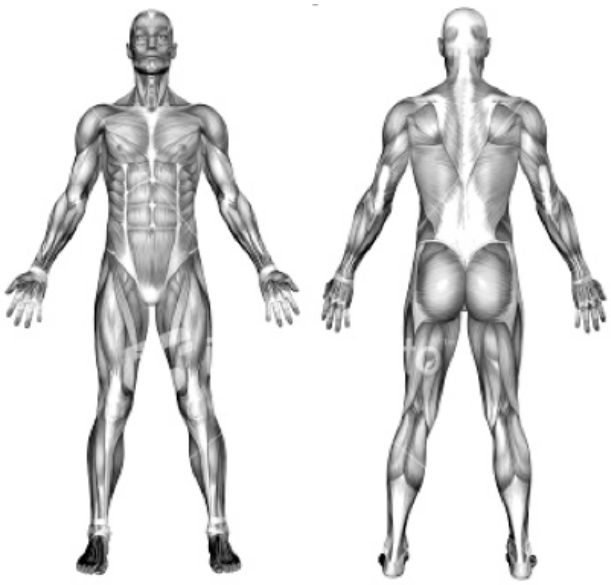
What makes you feel worse? _____

When do you last remember feeling really great? _____

Are you currently under the care of any of the following medical professionals?

❑ Medical Doctor	❑ Chiropractor	❑ Personal Trainer
❑ Nutritionist	❑ Acupuncturist	❑ Massage Therapist
❑ Psychiatrist	❑ Naturopath	❑ Physical Therapist

Please mark on the figures below where you are experiencing any discomfort, pain, or tension.



Please check any that apply:

Musculoskeletal System
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Bursitis
- ❑ Joint Pain
- ❑ Muscular Dystrophy
- ❑ Osteoporosis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Whiplash
- ❑ Carpal Tunnel Syndrome

Digestive System
- ❑ Acid Reflux
- ❑ Diarrhea
- ❑ Constipation
- ❑ Ulcers
- ❑ Food Allergies
- ❑ Gall Stones
- ❑ Hepatitis
- ❑ Recent change in appetite

Urinary System
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ UTI

Immune System
- ❑ Cancer
- ❑ Fibromyalgia
- ❑ Diabetes
- ❑ Edema
- ❑ HIV/AIDS
- ❑ Lupus
- ❑ Lymphoma
- ❑ Chronic Fatigue Syndrome

Nervous System
- ❑ Alzheimer's
- ❑ Headaches
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Seizures
- ❑ Sleep Disorders
- ❑ Shingles
- ❑ Spinal Cord Injury

Respiratory System
- ❑ Asthma
- ❑ Allergies
- ❑ Bronchitis
- ❑ Sinusitis
- ❑ Frequent Cold/ Flu

Integumentary System (Skin)
- ❑ Burns
- ❑ Dermatitis
- ❑ Eczema
- ❑ Fungal Infections
- ❑ Impetigo
- ❑ Scars
- ❑ Rash

Circulatory System
- ❑ Atherosclerosis
- ❑ Thrombosis
- ❑ Heart Attack
- ❑ Stroke
- ❑ Varicose Veins
- ❑ Poor Circulation
- ❑ High Blood Pressure
- ❑ Low Blood Pressure

Emotional System
- ❑ Depression
- ❑ Anxiety
- ❑ Grief
- ❑ Anger
- ❑ Other _____

PLEASE ANSWER ANY OF THE FOLLOWING QUESTIONS THAT CURRENTLY APPLY:

Age at 1st menstruation ____ Date of last menstrual period _____ Duration of flow _____

Length of Cycle: Less than 26 days 27-30 days Over 30 days Irregular

Color of flow: Bright Red Pale Red/Pink Dark Red/Purple Brown *Clots*: Yes No

PMS (please describe) _____

Current Method of Contraception_____ Past methods of contraception _____

Are you pregnant? Yes No Are you breastfeeding? Yes No

# of pregnancies_____ # of live births _____ # of miscarriages _____ # of abortions _____

Complications during pregnancy, labor, and/or breastfeeding? Yes No

Date of Last: Mammogram _____ Pap smear _____ Results _____

Age of Menopause _____ Are you currently on HRT? _____ Brand _____

Circle any that apply*:*

Uterine fibroids Endometriosis Pain/Itching of Genitals Frequent UTI's

Ovarian cysts Fibrocystic Breasts Frequent Yeast Infections PCOS PID

HPV Herpes Genital Warts Chlamydia Gonorrhea Syphilis HIV AIDS

Date of last: Prostate check up _____ PSA results _____

Manual prostate exam results _____ Lab results _____

Frequency of urinations: daytime_____ nighttime_____ Pain with urination? _____

Color of urine: clear murky dark yellow other _____ Any odor? _____

Please circle any that apply:

Dribbling urination Retention of urine Decreased libido Impotence

Premature ejaculation Testicular pain Delayed stream Incontinence

Rectal dysfunction Back pain Other _____

STD/STI's: Gonorrhea Syphilis AIDS Herpes Chlamydia Date(s) _____

Do you have any reproductive or sexual concerns you would like to discuss? Yes No

Do you have any emotional/physical/sexual trauma you would like to discuss? Yes No

Thank you for taking the time to complete this intake form. I look forward to working with you.
–Carla Nerelli, L.Ac

Please list any accidents, surgeries, or hospitalizations (*include approx date)*

_____
_____
_____
_____
_____

Please list any medications, vitamins, and herbs you are currently taking, including birth control pill or hormone replacement therapy

_____
_____
_____
_____

Do you have any known allergies?

_____
_____

Please indicate frequency of the following:

Water _____ Coffee _____ Soda _____
Tobacco _____ Alcohol _____ Drugs _____
Exercise: Type _____ How often? _____

Do you follow any special diet (vegan, kosher, keto, paleo)? _____

Family History of Disease: ❑ Cancer ❑ Stroke ❑ Heart Disease

❑ Emotional Disorders ❑ Diabetes ❑ Seizures ❑ High Blood Pressure
❑ Other: _____ ❑ Unknown

Thank you for taking the time to complete this intake form. I look forward to working with you.
–Carla Nerelli, L.Ac