KIRK HEALTH CLINIC, P.C.
1539 W. Andrew Johnson Hwy
Morristown, TN 37814
(423) 585-5556

ACUPUNCTURE INTAKE FORM **Date**________________________________

Last Name____________________________**First**____________________________**Middle**____________________

Preferred Name___________________________ Date of Birth_______________________ ❑ Male ❑ Female

Social Security #____________________________Age ____________Height_____________ Weight____________

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Widowed ❑ Other

Address____

City / State / Zip____

Home #____________________ Work #____________________ ext.________Cell #________________________

Name of Employer____

Employer Address____

Job Title____

Emergency contact (**name and #**) ____

Referred by: ❑Family: Name ____________________________ ❑ Friend: Name_________________________

❑ Internet ❑Yellow Pages ❑Other____

Have you ever had acupuncture? __________ If yes, when?____

for what condition?____ by whom?_____________________________

Are you currently under the care of a physician? ______________ If yes, who and for what condition(s)?

____

Have you seen any other health care provider for this condition? If yes, please explain diagnosis & treatment:____

____

Main reason(s) for seeking acupuncture today: ____

____

Date it began or when did you first notice symptoms: ____

Your condition is improved by? ____

Your condition is aggravated by? ____

List all current medications (prescribed or over the counter), vitamins, herbs and other supplements:

____

Please list any surgeries you've had including dates: ____

____

Please list any allergies: ____

Please list any major emotional or physical traumas you've experienced: ______________________________

____

Lifestyle (please check all that apply and note frequency of use):

____ Tobacco Frequency______________________
____ Alcohol Frequency______________________
____ Coffee Frequency______________________
____ Soft Drinks Frequency______________________
____ Tea Frequency______________________
____ Water Frequency______________________

Do you exercise? _________ Please list types of activity & frequency: ________________________________

____

Do you eat the following foods?

______ Red Meat ____ X per week
______ Fish ____ X per week
______ Artificial sweeteners ____ X per week
______ Fast Food ____ X per week

______ White flour breads, pretzels, etc.
______ Salads
______ Cooked Vegetables
______ Eggs

EMOTIONAL STRESS SCALE (1 is low, 10 is high) **Circle one: 1 2 3 4 5 6 7 8 9 10**

Do you suffer from? ________ Depression _______ Anxiety ________ Cry easily _______ Irritability

Are you pregnant? _____________ if yes list your estimated Due date?____________________________

Have you miscarried in the past 12 months? ____

Are you experiencing menopausal symptoms? _______ Please explain:_____________________________

____

Are you on Hormone Replacement Therapy? ____ Which type? __________________________________

____

PLEASE CHECK ANY OF THE FOLLOWING APPLY TO YOU:

WATER ELEMENT

___ Hearing Loss
___ Dizziness
___ Lower back/neck pain
___ Sinus congestion
___ Edema
___ Darkness under eyes
___ Emotional instability
___ Aversion to cold
___ Hair thinning or loss
___ Pre-mature aging
___ Frequent urination
___ Kidney stones
___ Perspire very easily
___ Weakness of legs/knees
___ Asthmatic cough
___ Rapid weight change
___ Loose teeth
___ Reduced sexual energy
___ Thyroid problems
___ Diabetes

WOOD ELEMENT

___ Headaches
___ Migraines
___ Ringing in ears
___ Poor eyesight
___ Eye infections
___ Dry eyes
___ Eczema
___ Shingles
___ Herpes simplex
___ Warts
___ Nervousness
___ Convulsion, spasms
___ Irritability
___ Constipation
___ Hemorrhoids
___ Hepatitis
___ Ulcer
___ Vomiting
___ Gallstones
___ Indecisive
___ Fullness below ribs
___ Shoulder / neck tension
___ Insomnia 11PM – 3AM

FIRE ELEMENT

___ Dry Scalp
___ Rashes, skin eruptions
___ Cysts, tumors
___ Ear infections
___ Sore throat/tonsillitis
___ Lymphatic swelling
___ Hot palms & soles
___ Heart Palpitations
___ Aversion to heat
___ Bitter taste in mouth
___ Gum problems
___ Nose bleed
___ Facial redness
___ Itching / burning skin
___ Hot hands / feet
___ Thirst
___ Vivid dreaming
___ Dark urine
___ Night sweats

METAL ELEMENT

___ Bronchitis
___ Asthma
___ Shallow breathing
___ Cough
___ Sinus congestion
___ Nasal infection

OTHER

___ Fatigue
___ Arthralgia
___ Sciatica / nerve pain
___Cold hands / feet
___ Tendonitis
___ Bursitis

EARTH ELEMENT

___ Indigestion
___ Flatulence
___ Food allergy
___ Stomach ache / ulcer
___ Diarrhea
___ Anemia
___ Halitosis
___ Sores in mouth
___ Heartburn
___ Strong appetite
___ Weak appetite
___ Nausea
___ Abdominal bloating
___ Low body weight

FEMALE CLIENTS ONLY

___ Vaginal infection
___ Yeast infection
___ Urinary tract infection
___ Ovarian cyst
___ Pelvic inflammatory disease
___ Excessive bleeding
___ Breast lumps
___ Irregular periods
___ Menstrual cramping
___ Pre-menstrual syndrome
___ Infertility
___ Genital burning
___ Positive PAP
___ Hemorrhoids
___ Anal fissure

____ # of children you have had

MALE CLIENTS ONLY

___ Prostatitis
___ Urinary incontinence
___ Nocturnal emission
___ Burning urination
___ Pre-mature ejaculation
___ Impotence

Anything you wish to add? ____

____

I authorize Dr. Mike D. Kirk to perform Acupuncture and to administer whatever treatment deemed necessary to treat my present condition (symptoms).

In addition to the above, I understand that I have been given the opportunity to read and review the Kirk Health Clinic, P.C. Notice of Privacy Policies.

The above information is true to the best of my knowledge. I clearly understand, accept and agree that all services rendered me are charged directly to me and that I am personally responsible for payment in full at the time of service. If payment is collected by an attorney, by suit or otherwise, I, or we, agree to pay all fees and collection costs.

Patient's Signature____ **Date**_____________

Guardian signature authorizing care_________________________________ **Date**_____________