



Skyline Wellness Center
4218 King Street
Alexandria, VA 22313
(703) 879-5144
fax (703) 879-5860
www.skylinewellnesscenter.com

Acupuncture Intake

Personal Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Height: _____ Weight: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____

How did you hear about our Clinic: _____

Current Health Condition

Describe your principle complaint: _____

When and how did this condition begin? _____

What worsens condition? _____

What offers relief? _____

What has been diagnosed by an M.D.? _____

Other Doctors seen for these conditions: _____

Other Complaints: _____

Do you have any scars? Note location of all scars: _____

Have you seen a licensed practitioner of medicine, osteopathic medicine, chiropractic or podiatry in the last six months? Yes No

Current Medications

List any medications, nutritional supplements, vitamins that you are currently taking: _____

Diet

Describe your diet: _____

Past Health History

Major Surgery: _____

Major Accidents/Falls: _____ Age: _____

Hospitalizations (other than above): _____ Age: _____

Significant illnesses: _____ Age: _____

Have you been treated for any health condition in the past year? Yes No

If yes, please explain: _____

Did you have any problems during your birth? _____

Have you had any unusual vaccinations? Did you have any reactions? _____

Do you have any reason to believe you're pregnant? _____

Family History

Note all major illnesses in your immediate family: _____

Below is a list of conditions which may affect your overall diagnosis, treatment plan and the possibility of being accepted for care. Please circle any of the following signs/symptoms that currently apply and underline those that affected you in the past : (need to eliminate boxes)

General Symptoms

Headaches
Fever
Chills
Night Sweats
Fainting
Dizziness
Convulsions
Insomnia
Fatigue
Nervousness
Loss of Weight
Arm/Hand Numb
Arm/Hand Pain
Leg/Foot Numb
Leg/Foot Pain
Neuralgia

Emotional Problems (Angry, Irritable, Stress, Anxious, Depressed)

Muscles & Joints

Weakness
Twitching
Stiff Neck
Backache
Swollen Joints
Tremors
Painful Tailbone
Mid/Upper Back Pain
Hernia
Spinal Curvature

Gastro-Intestinal

Poor Appetite
Poor Digestion
Excessive Hunger
Belching or Gas
Nausea
Vomiting
Stomach Pain
Constipation
Diarrhea
Colon Trouble
Hemorrhoids
Liver Trouble
Jaundice
Gall Bladder Prob.

Cardio-Vascular

Rapid Heart Beat
Slow Heart Beat
High Blood Press.
Low Blood Press.
Chest Pain
Prior Heart Cond.
Ankle Swelling
Poor Circulation
Varicose Veins
Stroke History
Palpitations

Eye/Ear/Nose/Throat

Poor Vision
Crossed Eyes
Pain in Eyes
Deafness
Earache
Ear Noises
Ear Discharges
Nasal Obstruction
Nose Bleeds
Sore Throat
Hoarseness
Sinus Trouble
Frequent Colds
Thyroid Problems
Tonsillitis

Skin or Allergies

Skin Eruptions
Itching
Bruise Easily
Dryness
Boils
Sensitive Skin
Hives
Allergies: _____
Eczema
Warts
Hay Fever

Respiratory

Chronic Cough
Spitting Blood
Spitting Phlegm
Chest Pain
Difficulty Breathing
Asthma/Wheezing
Genito-Urinary
Frequent Urination
Painful Urination
Blood in Urine
Kidney Infection
Kidney Stones
Bed Wetting
Urine Control Prob.
Prostate Trouble
Impotence

FOR WOMEN ONLY

Painful Periods
Excessive Flow
Irregular Cycles
Hot Flashes
Cramps / Backache
Miscarriage
Vaginal Discharge
Last PAP Smear
Date: _____

Have you had any of the following diseases?

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder: _____ |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Infection |

Habits

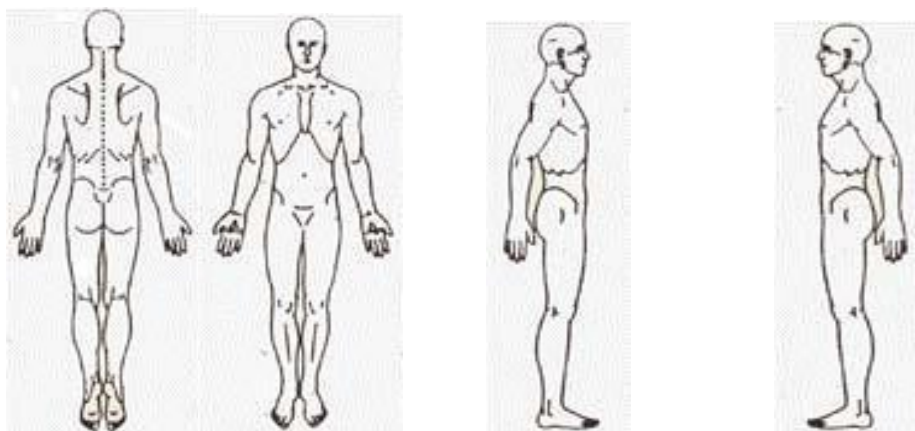
- Smoking __packs/day
 Alcohol __drinks/day
 Soft Drinks __cans/day
 Coffee __cups/day
 Chocolate __ounces/day

Exercise

- None
 Moderate
 Daily

 (Types of Exercise)

Please indicate with an (X), if any, the areas in which you are feeling discomfort/pain:



I hereby verify that all of the above information is true and correct to the best of my knowledge. I understand that Skyline Wellness Center does not submit Acupuncture Services to Insurance, and payment is due at the time of treatment. If I plan to submit the services to Insurance on my own, I understand that it is my responsibility to notify the Skyline Wellness Center staff BEFORE I receive treatment, in order to receive the proper documentation. I also understand for future appointments that there will be a \$50 cancellation fee for any appointments cancelled or missed without 24 hours notice to the office.

 Patient Name (Print)

 Date

 Patient Signature