

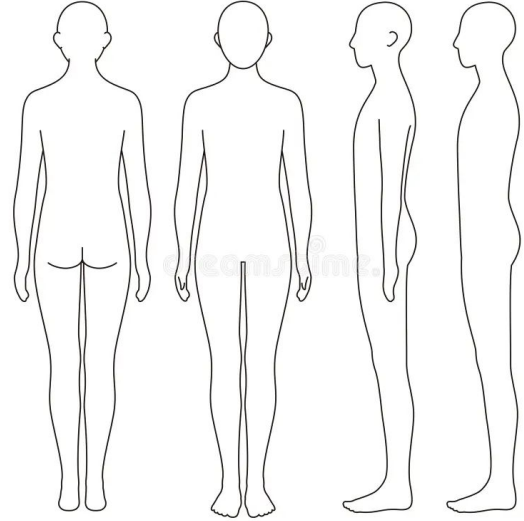
ORANGE SHOE ACUPUNCTURE
INTAKE FORM: ADULTS

FULL NAME:
DATE OF APPOINTMENT:
DATE OF BIRTH:

1 WHAT BRINGS YOU TO SEE ME?

2 WHAT ARE YOU EXPERIENCING, AND WHEN DO THESE SYMPTOMS SHOW UP (what time of day, time of month?)

3 DRAW WHERE THE SYMPTOMS ARE SHOWING UP.



4 ARE YOU LOOKING TO COME OFF ANY MEDICATIONS IN THE NEXT 3-6 MONTHS?

☐

YES

IF YES, WHICH ONE(S)?

☐

NO

5 HOW IS YOUR...

SLEEP?

DIGESTION?

LIBIDO?

5 ANY OTHER IMPORTANT HEALTH INFORMATION I SHOULD KNOW?

7 WHAT WILL IT LOOK LIKE IF/ WHEN THIS IS SUCCESSFUL? (e.g., I'll be able to run the marathon I've signed up for, sleep through the night, significantly decrease my back pain so I can easily walk on vacation, have more up days than down, eat my favorite foods without pain)?

BONUS QUESTION:

IF I COULD WAVE A MAGIC WAND AND GIVE YOU ANYTHING YOU WANTED, WHAT WOULD YOU WANT?