Good Medicine
Acupuncture and Massage
206 S 3rd Street West
Missoula, Montana, 59801
Phone: 406. 926. 1881

Initial Acupuncture Intake:

Personal Information

Patient Name:_____

Age:_____ Birth Date:_____/_____/_____ Gender:_____

Address:_____

City:_____State_____Zip_____

Telephone:_____

Email:_____

Referral Source:_____

Emergency Contact:_____Phone:_____

Main Complaint

Please identify your major health concerns:_____

_____

_____

_____

Have you been given a diagnosis for any of these health issues?:_____

_____

What other treatments have you tried?_____

_____

_____

Personal Medical History

Illnesses:_____

_____

Surgeries:_____

_____

Significant Trauma:_____

_____

History of current or past infectious disease? Please describe:_____

_____

Medication and Supplement list:_____

_____

Allergies and Sensitivities:_____

_____

Are you currently pregnant?: Yes or No
Do you have a pacemaker?: Yes or No

General [please mark or circle any current or past complaints]

❑ Poor Digestion	Vision Changes	Anxiety/Depression
❑ Dizziness	Fatigue	Poor Sleep
❑ Diarrhea/Constipation	Stress	Irritability
❑ Strong Thirst	Weight Loss/Gain	Cravings
❑ Puffiness and Swelling	Ringing in the ears	Asthma
❑ Night Sweats	Allergies	Arthritis
❑ Nausea	Poor Memory	Migraines/Headaches
❑ Heartburn/Indigestion	Rashes/Acne	Palpitations

Women only

Age of first menses?	Irregular Periods Y or N	Hot flashes Y or N
Date of last menses?	Painful Periods Y or N	Menopausal Y or N
# of days in cycle?	Fertility problems Y or N	Breast tenderness Y or N
# of births?	Spotting Y or N	Yeast infection Y or N
# of pregnancies?	Vaginal Discharge Y or N	PMS Y or N