



Initial Intake Form

Name _____ Cellphone _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Occupation _____

Date of Birth _____ Relationship status _____ Referred by _____

Emergency Contact and relationship _____ Phone _____

I authorize Stillpoint Acupuncture & Healing Arts to communicate files and/or NPI via email to me, I understand that I can revoke this authorization, in writing, at any time.

The following information will be used to help me plan a safe and effective treatment. Please answer the questions to the best of your knowledge.

Have you had Acupuncture before? Yes No

Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain _____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No

If yes, please explain _____

Do you have sensitive skin? Yes No

Are you wearing: contact lenses dentures a hearing aid prosthetics?

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe _____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe _____

How do you feel the stress in your work, family, or other aspects of your life affects your health, and what is the biggest stressor? Muscle tension Anxiety Insomnia Irritability

Other _____

Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort? Yes No If yes, please identify _____

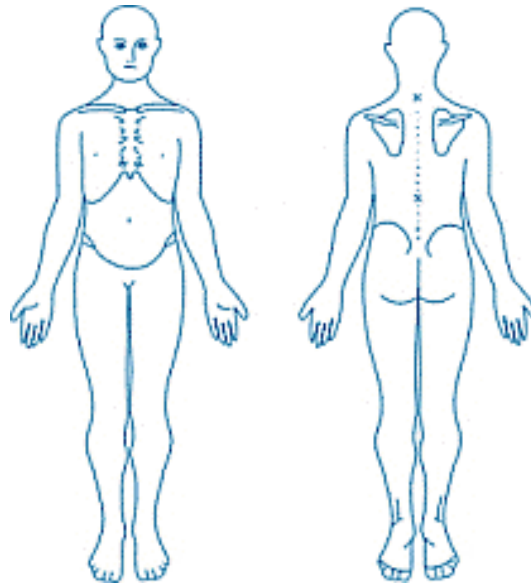
Medical History

Do you currently or have you ever had any of the following: (please check)

Phlebitis
Tennis elbow
Deep vein thrombosis/blood clots
Recent fracture
Joint disorder
Recent surgery (including plastic)
Rheumatoid arthritis/osteoarthritis/tendonitis
Artificial joint
Osteoporosis
Sprains/strains
Epilepsy
Current fever
Headaches/migraines
Swollen glands
Cancer
Allergies/sensitivity

Diabetes
Heart condition
Decreased sensation
High or low blood pressure
Back/Neck problems
Circulatory disorder
Fibromyalgia
Varicose veins
TMJ
Atherosclerosis
Carpal tunnel syndrome
Easy bruising
Contagious skin condition
Recent accident or injury
Open sores or wounds
Pregnancy If yes, how many weeks? ____

Please mark areas of pain and discomfort





Please state any hospitalization, medical procedures (including plastic surgery and Botox / fillers) and medical Test (MRI, CT scan...)

Are you currently under medical supervision? Yes No

If yes, please explain _____

Are you currently taking any medication? Yes No If yes, please list

Medication Name	Medical Condition

Please explain the reason(s) for your visit in the order of importance

1. _____
2. _____
3. _____

Anything else you would like me to know or be aware of?

I understand that the treatment I receive is provided for the basic purpose of enhancing my overall health and support the natural healing abilities of my body. If I experience any pain or discomfort during my session, I will immediately inform my practitioner. I further understand that this treatment **should not** be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that Eran Reznik is not qualified to perform adjustments, diagnose, prescribe medication, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. This is a complementary and supportive treatment only. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Eran Reznik Dipl.Ac., NCCAOM, LMBT and/or Stillpoint Acupuncture & Healing Arts updated as to any changes in my medical profile and understand that there shall be no liability on his part should I fail to do so.

Signature of client _____ Date _____