

**Dr. Jeffrey Turre**  
Licensed Acupuncturist

Acupuncture and East Asian Medicine Intake Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Permission to leave messages regarding your care on  Phone  Email

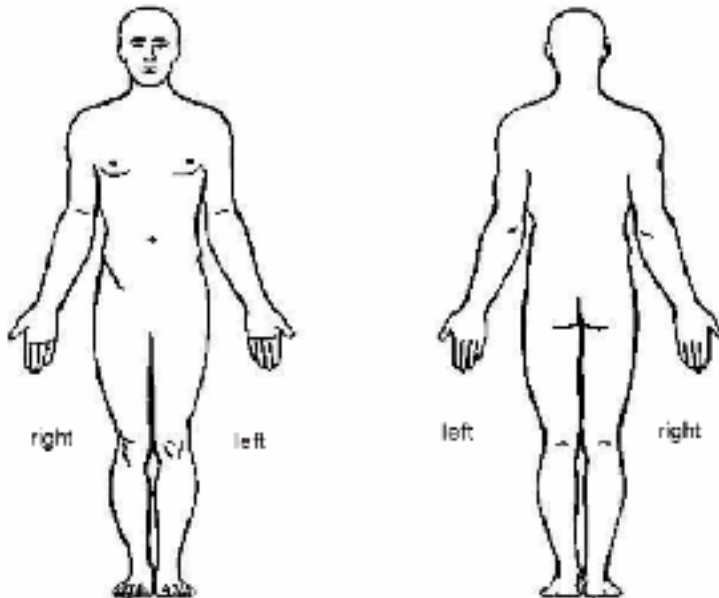
Have you had acupuncture before? Yes No If "yes", for what condition? \_\_\_\_\_

What are you interested in working on? \_\_\_\_\_

What current treatment are you receiving for your concerns? \_\_\_\_\_

(If your concerns include physical pain, please mark its quality and location below)

Location of pain: (please **circle** areas of pain or mark **X** for numbness/tingling)



**Circle quality of pain:**

- |              |          |
|--------------|----------|
| Throbbing    | Shooting |
| Stabbing     | Sharp    |
| Hot/ Burning | Aching   |
| Heavy        | Cramping |

**How often does this pain occur?**

- Continuously
- 1 or 2 times a day
- Several times a day
- Several days a week
- Less than 4 times a month

**How long have you had this pain?**

- 3 months or less
- 12-24 months
- 3-6 months
- More than 24 months

If known, what is the cause of the pain? \_\_\_\_\_



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**Family History - please complete by placing an X in the appropriate box:**

	Self	Mother	Father	Sibling	Grandparent
Diabetes					
Cancer/Tumor, Type:					
Seizures					
High Blood Pressure					
Substance Abuse					
Alcoholism					
Heart Disease					
Stroke					
Autoimmune Disorder, Type:					
Other:					

**Allergies**-please list known allergies and note severity (ex. medication, food, pollen)

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**Sleep**

What time do you typically go to sleep? \_\_\_\_\_

How many hours do you typically sleep? \_\_\_\_\_

Do you wake often/ have difficulty staying asleep? \_\_\_\_\_

Do you wake feeling rested? \_\_\_\_\_

**Stress Level** ( 0= typically no stress, 10= often very stressed) \_\_\_\_\_

**Major Hospitalizations/Health Emergencies**

Year                      Operation or Illness

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**Medications** - please list any current medications you are taking (use back of page for more space)

Drug Name	Dosage	Frequency

**Supplements and Herbs**

Name	Brand/Source	Dosage	Frequency

**Diet**

Recent changes to diet? \_\_\_\_\_

Drink coffee/caffeine? (amount, frequency) \_\_\_\_\_

Do you have a spiritual practice you consider part of your health? \_\_\_\_\_

What are your health goals? \_\_\_\_\_

Please list any additional health/wellness related information you would like to share on the back of this form.

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**To be completed by Acupuncturist**

**T:**

**P:**

LU/LI	HT/SI
SP/ST	LV/GB
PC/SJ	KI/UB

**Assessment:**

**EAM Dx:**

**EAM Tx Principles:**

**Treatment Plan:**

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**Release of Information**

All information provided herein is true and correct. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees and/or beneficiaries and other related persons. I have read and understood this release.

X \_\_\_\_\_ Date \_\_\_\_\_

**Payment Policy**

Payment of all services rendered is due at the time of service to Dr. Jeffrey Turre, LAc. I have read and understood this policy.

X \_\_\_\_\_ Date \_\_\_\_\_