Satori
Acupuncture of Knoxville
Your body can stand almost anything;
it's your mind that you have to convince.

Patient Intake Form

First name_____ Middle Init. ___ Last Name_____

Female/Male. (Circle one) DOB_____ Age_____

Street Address_____

City/State_____ Zip Code_____

Mobile Phone (___)_____ Home Phone (___)_____

Email_____ Marital Status _____ Occupation _____

Emergency Contact _____ Phone (___)_____

Referred by _____

Please describe the main reason for your visit today:

_____

_____

Does your job require periodic drug tests? Yes. No.
Do you have an issue or concerns with CBD products (topicals)? Yes. No.

Please indicate if you have any of the following conditions (check one):

- ☐ Pregnant
- ☐ HIV/Aids positive
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Cardiac pacemaker
- ☐ Seizure disorder
- ☐ Bleeding disorder/on blood thinners
- ☐ Fainting disorder
- ☐ Other (please specify)_____

Please also list any foods, medications or anything else you might be allergic to:

_____

_____

List all major childhood and adult illnesses, surgeries, major accidents and/or injuries:

_____

_____

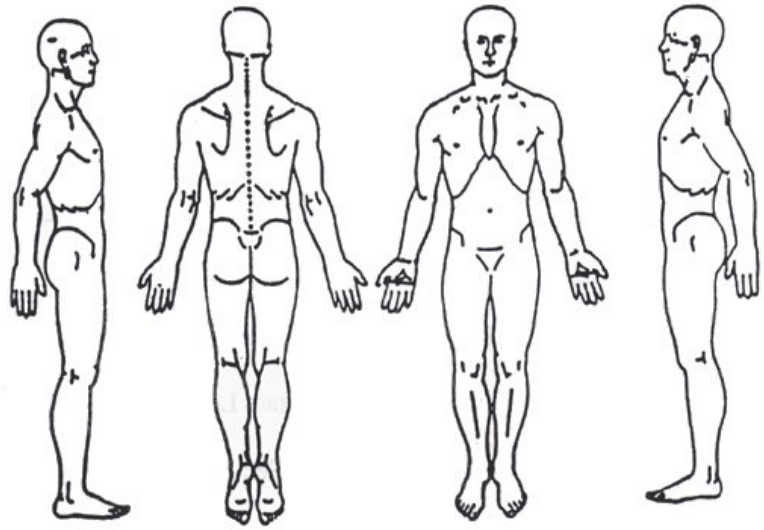
List any medications, supplements (incl. herbs and vitamins) you're currently taking:

_____

_____

Please check off any of the following that you indulge in (type and amount per week):

- ◻ Exercise _____
- ◻ Sugar/dessert/artificial sweeteners _____
- ◻ Coffee/Tea _____
- ◻ Caffeinated products (e.g. energy drinks, soda, etc.) _____
- ◻ Alcohol _____
- ◻ Drugs (*no judgment here…please be honest*) _____
- ◻ Salty foods _____
- ◻ Water intake (indicate # of glasses per day) _____



❑Poor Circulation to limbs and/or hands and feet.
❑Cold hands and feet
❑Fatigue
❑Heat sensation in hands and feet, chest or limbs
❑Night sweats
❑Catches colds easily
❑Sweats easily during daytime
❑Dizziness
❑Seeing floaters, prisms of light or black spots

❑Palpitations
❑Sores on tongue
❑Rashes or hives
❑Restlessness
❑Anxiety
❑Chest pain
❑Insomnia

❑Cough
❑Sinus congestion
❑Dry ENT
❑Allergies -Seasonal
❑Allergies -Food related
❑Chills/fever
❑Sore throat
❑Difficulty breathing

❑Low appetite
❑Loose stools
❑Constipation
❑Abdominal bloating
❑Bruises easily
❑General feeling of heaviness
❑Mental fogginess
❑Swollen hands/feet
❑Bad breath
❑Large appetite
❑Prone to mouth canker and cold sores
❑Painful, bleeding or swollen gums
❑Heartburn
❑Belching
❑Stomach pain
❑Nausea/vomiting

❑Diarrhea alternating w/ constipation
❑Skin Rashes
❑Angers easily
❑Migraines or Headaches
❑Tremors
❑Muscle spasms
❑Low back pain
❑Sore, cold or weak knees
❑Frequent urination
❑Incontinence (lack of bladder control)
❑Hair Loss
❑Memory problems
❑Tinnitus (ear ringing)
❑Libido is (circle one): Normal. Low. High

Please indicate distressed areas with an "x" and rate your level of pain on a scale of 1 (minimal pain) to 10 (a lot of pain).
Please check all symptoms that pertain to you at this current time.

❑ Please indicate any other symptom you're having that isn't listed on this form:

_____

<u>Women Only</u>
Are you pregnant now:
❑Yes.
❑No

Please answer even if you no longer have a menses.

Is/was your menses regular
❑Yes.
❑No.

Average number of days in flow:____

The flow is:
❑Normal.
❑Light.
❑Heavy.

The color is:
❑Bright red.
❑Dark Red.
❑Purple.
❑Brown.

Do/did you have any of the following menstrual related symptoms (circle all that apply):

❑Blood clots
❑Cramps
❑Nausea
❑Breast pain/tenderness
❑PMS
❑Break through bleeding between periods
❑Heavy vaginal discharge between periods

<u>Men Only</u>
Do you have any discomfort or issues with your reproductive organs (circle all that apply)?

❑Discharge
❑Pain or swelling of the testicles
❑Ejaculatory problems
❑Impotence/Erectile Dysfunction