SAAT Short Intake

Name_____ Date of Birth_____

Address_____City/State/Zip_____

Email: _____Can I email you? Y / N

How did you hear about me? _____ Age_____ M/F

Home phone _____Cell phone_____

Emergency contact/phone#_____

Pregnant? _____ On Blood Thinners? _____ Allergic to Latex? _____ Allergic to metals? _____ Allergic to alcohol? _____

Stress Level 0-10_____ History of heart issues? _____ Do you have a pacemaker?_____

Implants? _____ Any Piercings (other than ears)? If so, where? _____

Do you have: Cancer? _____ Hepatitis A,B,or C?_____ HIV?_____
Other?_____ List accidents, surgeries, major illnesses _____

_____

Medications/Supplements/Herbs _____

_____

Do you exercise? _____ Do you use saunas? _____

Eat/drink dairy? _____ Eat Gluten? _____ Eat meat? _____

Have you ever had acupuncture? _____

CHIEF COMPLAINTS HOW LONG HAVE YOU HAD THIS INTENSITY 0-10
1._____/_____/_____/_____

2._____/_____/_____/_____

3._____/_____/_____/_____

If you have pain, where is it located?

_____
_____

KNOWN OR SUSPECTED ALLERGIES/SEVERITY/TESTS?

1._____/_____/_____/_____

2._____/_____/_____/_____

3._____/_____/_____/_____

(If you need more space for answers, please use back of page)

Signature____ Date __________________