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Classical Acupuncture, Chinese Medicine and Asian Bodywork

Patient Information

Name: _____ Today's date: _____

Address: _____ Age: _____ Date of birth: _____

City: _____ State: _____ Zip: _____ Email: _____

Best phone to reach you: _____ Receive texts (please circle): Yes No

Marital Status: _____ Gender: _____ Occupation: _____

Referred by, or how you heard of us: _____

Emergency Contact (Name/Phone): _____
Relationship to you: _____

Primary Doctor (Name/Phone): _____

Are you under the care of a physician now? Yes No
If so, what for? _____

Current prescriptions, over the counter medications, and/or supplements: _____

Have you had acupuncture before: Yes No

Primary reason for seeking acupuncture: _____

How long have you had this condition? _____

Secondary reason for seeking acupuncture: _____

How long have you had this condition? _____

Are you receiving any other treatments for these conditions? (please specify) _____

If known, what seemed to be the initial cause? _____

Please check conditions that you have or have had in the past:

___Heart disease ___Stroke ___Diabetes ___Asthma
___Seizures/Epilepsy ___Alcoholism/Addiction ___High Blood Pressure
___Cancer ___Other: _____

___HIV/AIDS ___Epilepsy ___Allergies ___Bleeding disorder
___Emphysema ___Hypertension ___Ulcers ___Osteoporosis
___Hepatitis ___Pneumonia ___Anemia ___Thyroid condition
___Pacemaker ___TB ___Autoimmune
___Other: _____

Do you take anticoagulant medication? Yes No

Surgeries/History of hospitalizations: _____

List of broken bones: _____

Smoker: Yes No How much and how often? _____

Exercise: Yes No How much, how often, what type? _____

Alcohol consumption How much, how often? _____

Birth control method? _____ Number of children: _____

Please circle your current level of stress, 1 being lowest and 10 being highest:

1 2 3 4 5 6 7 8 9 10 11+

Temperature/Energy/Sleep

___Tend to be HOT
___Tend to be Cold
___Cold hands, feet
___Fever
___Difficulty falling asleep
___Night sweats
___Unusual/excess sweating
___Excessive thirst
___No thirst
___Restless sleep
___Chills
___Fatigue
___Body feels heavy/weak
___Feel wired/ungrounded
___Disturbing dreams

Hours of sleep per night?_____ Daily caffeine intake?_____

Mood/Emotions

___Anger easily
___Anxiety
___Depression
___Easily startled
___Fear
___Indecision
___Irritability
___Mood swings
___Sadness/grief
___Stress
___Worry
___Difficulty concentrating

Neuropsychological

___ADD/ADHD
___Bipolar disorder
___Mental illness
___Nervousness
___Poor memory

Musculoskeletal

___Back pain: upper/mid/lower
___Joint pain or weakness: hand/wrist elbow/shoulder/foot/ankle/knee/hip
___Muscle cramps/spasms
___Neck pain
___Weak muscles

Skin/Hair/Nails

___Acne
___Bruise easily
___Dry skin/Itchy skin/Oily skin
___Dry, brittle nails
___Hives
___Rashes/Eczema/Psoriasis
___Dry hair/Oily hair

Head/Eyes

___Dizziness/Vertigo
___Fainting
___Headaches
___Migraines
___Blurred or failing vision
___Cataracts
___Dry/Itchy/Red/Watery eyes
___Eye strain or pain
___Glaucoma
___Poor night vision

Ears/Nose/Throat/Mouth

___Ear infections
___Ear ringing
___Hearing loss
___Hay fever/allergies
___Nasal congestion
___Nosebleeds
___Sinus problems
___Difficulty Swallowing
___Dry throat
___Sore throat
___Hoarseness/Loss of voice
___Swollen glands
___Dry Mouth
___Mouth sores
___Gum problems
___Teeth grinding
___TMJ/Jaw problems

General amount/extent of dental work:_____

Respiratory

___Asthma or wheezing
___Bronchitis
___Chronic cough
___Shortness of breath
___History of childhood asthma
___Cough w/phlegm or blood
___Difficulty breathing
___Emphysema
___Frequent colds
___Pneumonia

Cardiovascular

___Chest pain/tightness
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Palpitations
___Poor circulation
___Rapid/irregular heart beat
___Swelling of ankles
___Varicose veins

Gastrointestinal

___Acid reflux/GERD
___Bad breath
___Belching
___Bloating and/or gas
___Blood in stool
___Constipation
___Diarrhea or loose stool
___Food allergies/sensitivities
___Hemorrhoids
___Indigestion
___Liver problem
___Gall bladder stones/problem
___Nausea
___Poor appetite
___Excessive appetite
___Stomach pain
___Ulcers
___Vomiting

Bowel movement frequency:_____ Formed or loose:_____
Color:_____ Strong odor:__Yes__No_____

Genitourinary

___Blood or pus in urine
___Frequent urination
___Incomplete urination
___Nighttime urination
___Unable to hold urine
___Urgent urination
___Painful/burning urination
___Urinary tract infection
___History of UTI
___Kidney stones
___Lowered sex drive
___Premature Ejaculation
___Prostatitis
___Impotence/Erection difficulties
___STD:_____

Gynecology/Reproduction

___Abnormal PAP smear
___Breast tenderness
___Clots with menses
___Heavy menstrual flow
___Irregular periods
___Mid-cycle bleeding/spotting
___Painful periods/cramps
___PMS
___Light menstrual flow
___Menopausal symptoms
___Previous miscarriage
___Vaginal discharge
___Vaginal dryness
___Yeast infections

Are you pregnant?_____ Date of last period:_____

Average length of cycle:_____ Duration of flow:_____

Date of last PAP exam:_____ Age of menopause:_____

Additional info:_____

Informed Consent

- Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.
- Your treatment may include the application of Moxabustion Therapy, Cupping Therapy, or hands-on massage/bodywork. These will be explained to you at the time of treatment.
- An Acupuncturist is not able to make a medical diagnosis, provide primary care, or Western (allopathic) medical care. Please see your doctor for those services and for routine check-ups.
- Acupuncture is generally safe. Serious side-effects are extremely rare.
- The purpose of Acupuncture is to reduce pain and to aid in bringing the body back to a normal state of balance. Because Acupuncture involves the insertion of needles into the skin, minor side-effects are rare, but may occur. These include bruising, slight bleeding, weakness, drowsiness, intense to subtle sensations during or following treatment, fainting, and increase or aggravation of symptoms during or following treatment.
- **Only sterile, one-time use, disposable needles are used. Needles are not re-used, even on different areas of the body on the same person.**
- Please inform your Acupuncturist:
  - If you have ever experienced a seizure, dizziness, or fainting episode
  - If you have a pacemaker or any other electrical implants
  - If you have a bleeding disorder
  - If you are taking anticoagulants or any other medications
  - If you have damaged heart valves or high blood pressure
  - If you have any form of infection
  - If you are pregnant

With this knowledge, I voluntarily consent to receiving Acupuncture. I understand that I can refuse treatment at any time.

Printed name:_____

Signature:_____ Date:_____

Financial Policy

- Payment is expected at time of visit
- Cash or checks accepted
- Insurance is not accepted at this time, but a receipt may be provided for you to submit yourself
- If current fees are the only thing stopping you from scheduling regular treatments, please speak with me regarding the availability of payment options

Cancellation Policy

- **Please give 24 hours notice if you need to cancel or reschedule an appointment**
- In cases where appointments are cancelled, or missed altogether without notification:
  - The first time will be free of charge
  - The second time, there will be a charge equaling 50% of the expected treatment fee
  - The third time, there will be a full charge of the expected treatment fee and a consultation as to whether treatments should continue to be scheduled
- It is understood that emergencies happen. If an emergency causes you to miss your appointment, please speak with me.

Signature:_____ Date:_____