Acupuncture Works

Acupuncture Full Intake Form

Patient Name:_____Date:_____
Address: _____ City:_____State:____ Zip:_____
Phone- Home:_____Cell:_____
*Please circle your preferred number for us to contact you at
Date of Birth:_____Age:_____ Email:_____
Marital status:__M__S__W__D Occupation:_____
Emergency Contact:_____ Phone:_____
Physician's Name:_____ Phone: _____
Height:_____ Weight:_____ Allergies (To medications):_____
Medications currently taking: _____

Insurance Carrier:_____ ID#:_____
Group number:_____Telephone number: _____
Insured's Name:_____ Relationship to insured:_____
***If self disregard below***

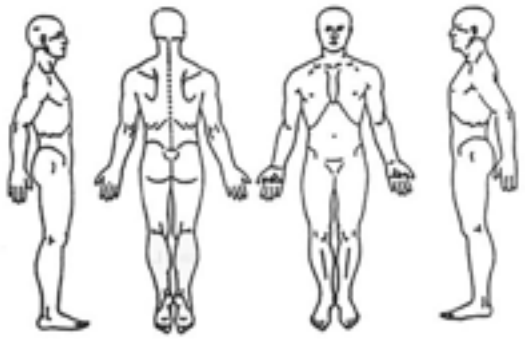
Insured's Name:_____ Insured's Date of Birth:_____
Insured's Address:_____
Insured's SS#:_____ ID#:_____
Insured's Phone:_____ Insured's Gender: Male Female

**What is the problem that brought you here today?**_____
**WHAT IS THE PHYSICIANS DIAGNOSIS?**
_____
When did the problem first appear?_____
What was the initial cause? _____
What makes it worse?_____What makes it better?_____
How does this problem interfere with your daily activities? (please circle all that apply)

| | | |
|---|---|---|
| Work | Sleep | Walking |
| Sitting | Standing | Emotional |
| Relationships | Social Life | Sexually |
| Recreation | Bending | Stretching |
| Other _____ | | |

What have you done about this? _____
What are your health goals?_____
List any past or future surgeries: _____
List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, ect.)
_____
_____

Pain
Use the diagram and pain key below to indicate areas and types of pain



**Pain Key**

Ache
^ ^ ^ ^

Numbness
= = = =

Pins & Needles
0 0 0 0

Burning
X X X X

Stabbing
/ / / /

Use the chart below to indicate pain intensity and limitations *(please circle selection)*

**Pain intensity levels**

| No pain | Moderate Pain | Severe pain | Terrible Pain |
|---|---|---|---|

**Sleeping**

| No problem | Disturbed | Very disturbed | Cannot sleep |
|---|---|---|---|

**Work- Can do:**

| Usual Work | 50% of Work | 25% of Work | No Work |
|---|---|---|---|

**Recreation- Can do:**

| All activities | Some activities | No activities |
|---|---|---|

**Travel**

| No problem | Moderate pain on trips | Severe pain |
|---|---|---|

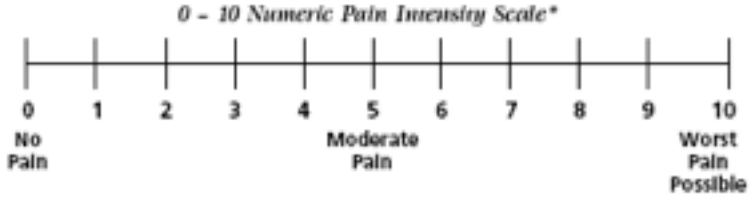
**Walking**

| Can walk fine | Pain after ½ mile | Cannot walk |
|---|---|---|

**Sitting**

| No pain sitting | Some pain while sitting | Cannot sit |
|---|---|---|

**Circle number on pain scale below**



**General Health** *(please circle all that apply):*

Poor Appetite Disturbed Sleep Insomnia Fatigue Poor Coordination Weight Gain Cold Hands and Feet Night Sweats Cold Abdomen Tremors Large Appetite Localized Weakness Strong Thirst Weight Loss Fevers Poor Balance Bruise/ Bleed Easily Sweat Easily Cravings (explain) _____ Chills Sudden Energy Drop Soft/ Brittle Nails Catch Colds Easily Other (please specify):_____

**SYMPTOMS: Check symptoms you currently have or have had in the past years**

**EYE, EAR, NOSE, THROAT**

__ Eye Pain/Strain
__ Dry Eye
__ Excess Tearing
__ Blood Shot
__ Double Vision
__ Dizziness
__ Fainting
__ Blurred Vision
__ Crossed Eyes
__ Floaters/Flashes
__ Eye Trauma
__ Glasses/Poor Vision
__ Night Blindness
__ Blind Field of Vision
__ Discharge From Eyes

__ Ear Discharge
__ Ringing in Ears
__ Ear Pain
__ Hearing Loss
__ Ear Infection
__ Excess Wax

__Nose Bleeds
__ Sinus Problems
__ Hay Fever
__ Food Sensitivities
__ Runny Nose
__ Sinus Infection
__ Congestion
__ Allergies

__Sore Throat-Recurrent?
__ Dry Throat
__ Hoarseness
__ Persistent Cough
__ Bleeding Gums
__ Loose Teeth
__ Swollen Tonsils/Discharge
__ Swollen Lymph Nodes
__ Difficulty Swallowing
__ Chills __Fever
__ Shortness of Breath
__ Scores on Lips or Tongue

**Other:**_____

**HEAD**

__ Migraine
__ Clicking Jaw
__ Loss of Balance

__ Headache
__ Concussion
__ Vertigo

__ Facial Pain
__ Head Hair Loss
__ Foggy Feeling

__ Grinding Teeth
__ Seizures/Ticks/Palsy

**Other:**_____

**SKIN**

__ Dry Skin
__ Acne
__ Bruise Easily
__ Hair Loss
__ Ulcerations

__ Itchy Skin
__ Sensitive Skin
__ Change in Moles
__ Hot Flashes

__ Eczema
__ Dandruff
__ Scars
__ Red Cheeks

__ Psoriasis
__ Rashes
__ Perspire Easily
__ Hives

**Other:**_____

**RESPIRATORY**

__ Cough __ Coughing Blood __ Asthma
__ Pneumonia __ Coughing Phlegm __ Pain with Deep Breath
__ Shortness of Breath __ Bronchitis __ Nasal Congestion
__ Difficulty Inhalation __ Difficulty Exhalation __ Wheezing
__ Difficulty Breathing when Lying Down

**Other:**_____

**GENERAL GASTROINTESTINAL**

__ Nausea __ Vomiting __ Diarrhea __ Constipation
__ Gas __ Bloating __Belching __ Bad Breath
__ Abdominal Pain/Cramps __ Indigestion __Heartburn/Reflux __ Excessive Appetite
__ Rectal Pain/Bleeding __ Black Stools __ Blood in Stool __ Hemorrhoids
__ Sensitive Abdomen __ Retention of Food in Stomach __ Burping
__ Chronic Laxative Use __ Poor Appetite __ Unexplained Weight Loss
__ Excessive Thirst

**Other:**_____

**GENITO-URINARY**

__ Pain on Urination __ Frequent Urination __ Blood in Urine __ Urgency to Urinate
__ Unable to Hold Urine __ Kidney Stones __ Decrease in Urine Flow
__ Impotence __ Sores on Genitals __Waking at Night to Urinate
__ Dribbling Post Urination __ Change in Sex Drive
__ Frequent Urinary Tract Infections

**Other:**_____

**MEN ONLY:**

__ Erection Difficulties __ Testicular Lump __ Penis Discharge
__ Prostate Enlargement __ Cold Feelings in Genitals
__ Testicle Pain __ Penis Pain __ Penis Sores
__ Premature ejaculation __ Impotence
__ Nocturnal Emission

**Other:**_____

**WOMEN ONLY:** Are you Pregnant? __ Yes __ No Trying to conceive? __ Yes __ No
Problems with conception? __ Yes __ No
Age of 1st Period_____ Age at menopause_____
# of Pregnancies ____# of live births_____
# of premature births ____ # of Miscarriages/Abortions_____
# of days between periods____ # of days of flow_____
__ Breast Lump/Swelling __ Hot Flashes __ Nipple Discharge
__ Vaginal Discharge __ Painful Intercourse
__ Abnormal Pap Smear __ Painful menses __ Irregular menses
__ Vaginal Odor __ Fibroids __ Ovarian Cysts
__ Sexually Transmitted Disease __ Vaginal Dryness
__ Decreased Sex Drive __ Strong menstrual odor
__ Urinary Tract Infection __ Premenstrual symptoms

**Other:**_____

Describe Menstrual Cycle

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| **Color** (normal,bright red, pale, brown, rust, dark, purple, other) | | | | | | | |
| **Flow** (light, heavy, normal) | | | | | | | |
| **Clots?** (small, large, red, dark) | | | | | | | |
| **Pain/Cramps** (dull, ache, sharp) | | | | | | | |
| **Nausea/vomit** | | | | | | | |
| **Energy level** (normal, low, high) | | | | | | | |
| **Headaches** (dull, moderate, severe) | | | | | | | |

**MUSCULOSKELETAL**
__ Neck Pain __ Back Pain __ Knee Pain __ Muscle Pain __ Foot/Ankle Pain
__ Shoulder Pain __ Hip Pain __ Hand/Wrist Pain __Sciatica
__ Muscle Weakness
**Other:**_____

**PSYCHOLOGY AND NEUROLOGICAL**

__ Seizures __ Dizziness __Loss of Balance __ Areas of Numbness
__ Poor Memory __ Lack of Coordination __ Concussion
__ Depression __ Anxiety __ Easily Stressed __ Confusion
__ Attempted Suicide __ Irritable __ Mania __ Panic Attacks
__ Mood Swings __ Worried __ Emotional Problems
__ Lack of Concentration __ Bad Temper/Violent Outburst
__ Seasonal Affective Disorders
**Other:**_____

**SLEEP**

__ Can't fall asleep but once asleep stays asleep __ Wakes Easily __ Irritability
__ Tossing and Turning __ Wake Up Early __ Easily Awakened
__ Grinds Teeth in Sleep __ Restless Sleep __ Dream Disturbed Sleep
__ Sleep Apnea __ Violent Dreams __ Dreamless Sleep
__ After Eating Lethargy or Sleepiness __ Fatigue After Eating
__ Wake Up During the Night __ Excessive Dreaming
**Other:**_____

**AUTOIMMUNE AND INFLAMMATORY**

__ Hashimoto's Disease (thyroid) __ Rheumatism __ Systemic Lupus
__ Erythematous __ Colitis __ Crohn's __ Alopecia (baldness)
__ Food Allergy __ Atopic Dermatitis __ Neurodermatitis
__ Cellulitis __ Sinus Allergy __ Vulvitis
**Other:**_____

**Family Medical History** *(circle all which apply & **specify which blood relative**- parents, grandparents, siblings)*

Cancer High Blood Pressure Hepatitis Rheumatic Fever Infectious Disease Heart Disease Seizures Emotional Disorder Tuberculosis
**Other (please specify):**_____

_____

**MEDICATIONS AND SUPPLEMENTS**
List medication and supplements you are currently taking

_____
_____

**ALLERGIES**
To medications or substances

_____
_____

**HOSPITALIZATIONS and SURGERIES**

_____

**Do you have any scars?** (note location of all operations or injury scars, even minor ones)

_____

_____

**Beverage intake/Smoking/Recreational** *(circle or fill out where necessary)*

Coffee Black Tea Caffeinated Beverages Recreational Drugs
Tobacco- Yes No Ever Smoked? Yes No - If yes, when quit:_____
a. If smoking, how many cigarettes do you smoke daily? __ b. How many packs do you smoke daily?___
Alcohol- Yes No Amount per day____ Per week___
Exercise (please specify type, how often, and length of time):_____

**Lifestyle** *(Please circle and elaborate where necessary)*

Hobbies Yes No
Type:_____ If no, why?_____
Do you feel you maintain a healthy balance between work and relaxation? Yes No
If no,explain_____
Travel: Places visited within the past year (any out of country travel?)_____
Working Environment: Good Bad (explain)_____
Home Environment: Good Bad (explain)_____

The information that I have documented on this form is accurate and I will advise the practitioner of any changes in my health or changed in my medications, nutritional supplements, and dietary habits. I will not hold my doctor or any members of his and her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient:_____Date:_____
Signature of Practitioner:_____Date:_____

## ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)