Acupuncture & Herbs

Acupuncture, Herbology, Pain Management, Massage Therapy

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Patient Intake Form

Welcome to Acupuncture & Herbal. Please help us by taking the time to fill out this questionnaire carefully. Even though some of the questions may seem unrelated to your condition, they may play a contributing role in diagnosis and treatment. All of your information will be confidential. Please let us know if you have any questions.

Contact Information Today's Date:___/___/______

Name:______________________________________ Sex: F ☐ M ☐ DOB:___/___/____ Age:____

Street:______________________________________ Email Address:________________________

City:___________________ State:_____ Zip:_________ Phone Number:___________________

Marital Status: M ☐ S ☐ D ☐ W ☐ Occupation:________________________

Employer:________________________Emergency Contact:________________________

Phone:___________________

How did you find out about us? Direct Mail ☐ Location or Walk By ☐ Friend/Relative ☐ Website ☐ Other ☐

___________________ Referred By:_________________

Have you had acupuncture before? Y ☐ N ☐ Allow email/mail/phone contact? Y ☐ N ☐

Primary Insurance Company: ___________________ ID #:______________

Group #:______________

Name of Insured:________________________ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Insured's Date of Birth:_____/_____/_____

Secondary Insurance: ________________________ ID #:______________

Group #:______________

Name of Insured:________________________ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Insured's Date of Birth: _____/_____/_____

Major Health Complaint(s)

Please list in order of significance to you and **check which you would like us to focus on today**.

1. ☐________________________________ 4. ☐________________________________

2. ☐________________________________ 5. ☐________________________________

3. ☐________________________________ 6. ☐________________________________

When did the checked problem begin?____

What are the precipitating factors?____

Have you been given a diagnosis for this problem? If so, please describe.______________________

What kind of treatments have you tried?____

What makes this problem worse?_______________________ Better?_______________________

Is there anybody in your family with the same problem?___________________________________

Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies etc.

____

Known allergies (food, medications, or other):____

Significant trauma (car accident, sports injuries etc.):____________________________________

Hospitalizations/Surgeries (procedures and dates):______________________________________

____

Current Health & Lifestyle

Do you smoke? Y ☐ N ☐ If yes, how many per day?_____ For how long?_____

Do you exercise? Y ☐ N ☐ If yes, how many times per week?_____ Please Describe.____________

How many hours do you sleep in general?_____ When do you usually go to bed?_____

Overall, do you feel that your lifestyle contributes to or takes away from your health?

____

____

Diet

Soft drinks per day_____ Cups of tea per day_____ Cups of coffee per day_____

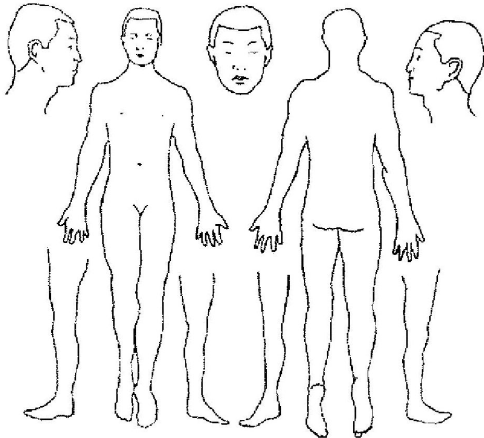
Glasses of water per day_____ Alcoholic beverages per week_____

Are you a vegetarian? Y ☐ N ☐ Yes, but not strict ☐ Explain:____________________________

Foods you tend to crave:____

Please indicate painful or distressed areas by using the symbol that best describes the feeling:

Mark with appropriate symbols:	
XXX	Sharp / Stabbing
PPP	Pins and Needles
DDD	Dull / Aching
NNN	Numbness



Please rate your **current** level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe

Comment:____

____

____

Profile

Please check any of the following symptoms that **currently** pertain to you.

General

☐Cold hands	☐Hot body temperature	☐Profuse perspiration	☐Chills
☐Cold feet	☐Cold body temperature	☐Lack of perspiration	☐Fever
☐Sweaty hands	☐Afternoon flushing	☐Perspire easily	☐Strong thirst
☐Sweaty feet	☐Hot flashes	☐Night sweating	☐Lower back pain
☐Frequent cavities	☐Hearing loss	☐Weak knees	☐Cold lower back
☐Broken/loose teeth	☐Ringing in ears/tinnitus	☐Knee soreness	☐Cold hips/buttocks
☐Weak bones	☐Early graying of hair	☐Hair loss	☐Cold knees
☐Dizziness	☐Forgetfulness	☐Fainting	☐Weak nails

Emotions

☐Mood swings	☐Anxiety	☐Fits of laughter	☐Fear
☐Sadness	☐Panic attacks	☐Depression	☐Frequent worrying
☐Nervousness	☐Irritability	☐Anger	☐Easily stressed
☐Bipolar	☐Obsessive/Compulsive	☐Mania	

Skin

☐Acne	☐Dry or Flaky Skin	☐Hives	☐Rashes
☐Dandruff	☐Eczema	☐Psoriasis	☐Ulcerations/Boils

Neuro-Muscular

☐Seizures	☐Lack of coordination	☐Tingling in extremities	☐Numbness
☐Paralysis	☐Loss of balance	☐Muscle spasms	

Cardiovascular

☐Heart palpitations	☐Chest Pain/Angina	☐Tongue ulcers	☐Speech impediment
☐Restless dreams	☐Mental restlessness	☐Insomnia	☐Hallucinations

Respiratory

☐Persistent cough	☐Nasal dryness	☐Chest congestion	☐Chest tightness
☐Nosebleeds	☐Chronic allergies	☐Sneezing	☐Difficulty Breathing
☐Sinus congestion	☐Sore throats	☐Wheezing	☐Shortness of breath
☐Frequent colds/flu			

Gastrointestinal

☐Indigestion	☐Low or weak appetite	☐Fatigue following a meal	☐Hypoglycemia
☐Abrupt weight gain	☐Gurgling in intestines	☐Easily fatigued	☐Strong cravings
☐Abrupt weight loss	☐Bruise easily	☐Gas	☐Hemorrhoids
☐Stomach ache	☐Ravenous appetite	☐Stomach ulcer	☐Nausea
☐Acid reflux	☐Bleeding gums	☐Belching	☐Vomiting
☐Bad breath	☐Heartburn	☐Hiccups	☐Mouth ulcers
☐Loose stools	☐Blood in stools	☐Less than 1 BM per day	☐Constipation
☐Mucous in stools	☐Difficulty moving bowels	☐Small, hard, dry stools	☐Diarrhea

Lymphatic System/Accumulated Dampness

☐Swollen hands	☐Mental fogginess	☐Edema in the legs	☐Heavy limbs/head
☐Swollen feet	☐Mental sluggishness	☐Edema in the abdomen	☐Joint stiffness

Liver/Gall Bladder Function

☐Headaches ☐Migraines ☐Pain in ribcage ☐Gall stones ☐Chronic neck or shoulder tension

Eyes

☐Itchy eyes	☐Watery eyes	☐Poor night vision	☐Cataracts
☐Dry eyes	☐Red and irritated eyes	☐Floaters/Seeing spots	☐Glaucoma
			0☐Blurry vision

Urinary

☐Cloudy	☐Small amount	☐Night-time urination	☐Incontinence
☐Dark yellow	☐Large amount	☐Difficulty initiating urination	☐Strong odor
☐Clear color	☐Dribbling	☐Very frequent	☐Pain or burning
☐Reddish color			

Male

☐Prostate Problems	☐Testicular pain/swelling	☐Ejaculation problems
☐Low sex drive	☐Premature ejaculation	☐Erectile dysfunction/impotence
☐Nocturnal emission	☐Infertility	☐Difficulty maintaining an erection
☐Low sperm count	☐Poor sperm motility	☐Irregular sperm morphology
☐Feeling of coldness or numbness of genitalia		☐Discharge

Do you have any bothersome symptoms? Y ☐ N ☐ Describe:________________________________

Do you get up at night to urinate? Y ☐ N ☐ How often?____

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

____

Have you sought medical intervention for these problems? If so, when?____________________________

____

What treatment have you tried for these problems and how successful have they been?

____

Female

☐Pelvic infection ☐Endometriosis ☐Vaginal dryness ☐Frequent vaginal infections
☐Fibroids ☐Ovarian cysts ☐Abnormal pap smear ☐Abnormal vaginal discharge
☐Breast tenderness ☐Breast lumps ☐Spotting between periods ☐Hot flashes
☐Low sex drive ☐Fertility problems ☐Pain during intercourse ☐Night Sweats

Do you experience any of the following associated with your period each month?
☐Water retention ☐Migraine/Headache ☐Lower back pain ☐Change in bowel movement
☐Mood swings ☐Irritability ☐Abdominal cramps ☐Breast tenderness/swelling
☐Food cravings ☐Acne ☐Heavy bleeding ☐Scanty/light bleeding
☐Clots ☐Other:____

_____number of pregnancies _____number of live births _____miscarriages _____abortions

_____premature births _____difficult delivery _____cesareans

At what age did you get your first period:_____ First day of last menstrual period:___________________

Are your menstrual cycles spaced regularly? Y ☐ N ☐ Cycle length:______ Period length:______

Are you currently using birth control? Y ☐ N ☐ If yes, what type and for how long?_______________

Have you experienced menopause? Y ☐ N ☐ When?____

If you are experiencing menopausal symptoms, please describe:________________________________

____

____

Is there any possibility you are pregnant now? Y ☐ N ☐

____

Patient Signature Date

PATIENT NAME: ____

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 be 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 involved 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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.

______________________________ ____________ ________________________

Patient Signature (or Patient Representative) | Date | (Indicate relationship if signing for patient)

______________________________ ____________

Acupuncturist Signature | Date