Acupuncture Intake Form

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Sex: ❑ Female ❑ Male SSN#: _____

_____ Marital Status: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Physician /Referring Physician: _____ Phone: _____

How did you hear about us? _____

Have you received acupuncture before? ❑ Yes ❑ No If yes, when & for what? _____

Informed Consent for Acupuncture Services

I acknowledge that acupuncture services being rendered to me are being performed by a NY State Licensed Acupuncturist.

I consent to acupuncture treatments and related procedures, associated with Oriental Medicine. I have discussed the nature and purpose of my treatment with the Acupuncturist and I understand that the methods of treatment may include, but are not limited to, acupuncture, cupping, gua sha and electrical stimulation.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needle sight, which may last a few days. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, however since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what he/she thinks is in my best interest, based upon the facts that are known at the time. I understand that the practitioner may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent. I will notify the acupuncturist, who is caring for me, if I become pregnant.

By voluntarily signing below, I agree to the following:

That I have read or have had read to me, this consent to treatment. I have been told about the risks and benefits of acupuncture and other procedures and had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek acupuncture treatment(s). I understand that I have the option to discontinue treatment at any time.

I affirm that I have been advised by the licensed acupuncturist to consult a physician regarding the condition or conditions for which I am seeking acupuncture treatment.

_____ _____ _____

Signature Print Name Date

Credit Card on File:

In order to expediate your billing we offer a credit card on file option for payment of all fees,deductibles,co-payments and co-insurances. Your card will be billed monthly and you will receive a paid statement and your credit card recipts.

Card Type: Visa MasterCard American Express **Security Code: _____

Card#: _____ Exp: _____

Patient Signature:_____ Date:_____

Name: _____ Date of Birth: _____

Chief Complaint: _____

How long have you had this problem? _____

What seems to cause this problem? _____

Have you been given a diagnosis? ❑ Yes ❑ No If yes, what? _____

To what extent does this problem interfere with your daily activities? (work, exercise, sleep, sex, etc.)?

_____

What kinds of treatments have you tried? How did your condition change? _____

_____

What makes it better? _____ Worse? _____

Please rate your current pain/discomfort: very slight ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 unbearable

List any other health problems you have: _____

Medical History

Please check any of the following that have affected you and indicate date:

- ❑ Addiction
- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Breast lumps
- ❑ Breathing problems
- ❑ Bronchitis
- ❑ Bursitis
- ❑ Cancer _____
- ❑ Candida
- ❑ Chicken Pox
- ❑ Chronic fatigue
- ❑ Colitis/bowel disease
- ❑ Diabetes
- ❑ Digestive disorders
- ❑ Eating disorder
- ❑ Elevated liver enzymes
- ❑ Emotional imbalance
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Gall stones
- ❑ Glaucoma
- ❑ Goiter
- ❑ Heart disease
- ❑ Hernia
- ❑ Hepatitis
- ❑ Herpes
- ❑ High cholesterol
- ❑ Hypertension
- ❑ Hypotension
- ❑ HIV positive
- ❑ Kidney stones
- ❑ Malaria
- ❑ Measles
- ❑ Meningitis
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Nephritis
- ❑ Neuralgia
- ❑ Paralysis
- ❑ Poisoning
- ❑ Prostate problems
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Stroke
- ❑ STD _____
- ❑ Thyroid problem
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Urinary problems
- ❑ Whooping cough
- ❑ Other: _____
- _____
- _____
- _____

List surgeries, hospitalizations, or significant traumas (accidents, falls, loss of loved ones, etc.) + Date:

_____

_____

_____

Medications taken in the last 3 months + Reason for taking them:

_____

_____

_____

Allergies + Adverse reactions: _____

Do you have a Pacemaker? ❑ Yes ❑ No Do you bleed for a long time? ❑ Yes ❑ No

Do you currently have: ❑ Cold/Flu ❑ Infection/Inflammation ❑ Menstruation ❑ Pregnancy/Lactation

Personal/Social History

How many hours per night do you sleep? _____ When do you usually go to bed? _____ Do you wake rested? ❑Yes ❑No

Do you exercise regularly? ❑Yes ❑No What kind of exercise? _____

What are your hobbies/things you most enjoy doing? _____

Are you or have you been on a restricted diet? What kind & why? _____

Please indicate the use and frequency of the following:

Cigarettes ❑No ❑Yes: How many per day? _____ Since when? _____ Alcohol ❑No ❑Yes: Amount _____

Drugs ❑No ❑Yes: Type _____ Amount _____ Since when? _____ Coffee ❑No ❑Yes: Amount _____

Water ❑No ❑Yes: Amount _____ Tea ❑No ❑Yes: Amount _____ Soda ❑No ❑Yes: Amount _____

Please describe your average daily diet:

Morning _____

Afternoon _____

Evening _____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments
Significant other	❑	❑	❑	❑	❑	_____
Family	❑	❑	❑	❑	❑	_____
Diet	❑	❑	❑	❑	❑	_____
Sex	❑	❑	❑	❑	❑	_____
Self	❑	❑	❑	❑	❑	_____
Work	❑	❑	❑	❑	❑	_____
Spirituality	❑	❑	❑	❑	❑	_____

Symptom Survey

Please check any of the following that applies to you now or in the past 3 months:

General

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Poor appetite	❑	❑	Allergies	❑	❑	Nervousness
❑	❑	Excessive appetite	❑	❑	Fever	❑	❑	Poor coordination
❑	❑	Strong thirst	❑	❑	Chills	❑	❑	Vertigo/Dizziness
❑	❑	Poor sleeping	❑	❑	Localized weakness	❑	❑	Bleed or bruise easily
❑	❑	Fatigue	❑	❑	Bodily heaviness	❑	❑	Tremors
❑	❑	Night sweats	❑	❑	Weight loss	❑	❑	Mood change
❑	❑	Sweat easily	❑	❑	Weight gain	❑	❑	Cold hands or feet
❑	❑	Swollen glands	❑	❑	Sudden energy	❑	❑	Hot/cold intolerance
❑	❑	Frequent infection			when? _____			
❑	❑	Other: _____						

Psychological

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Depression	❑	❑	Bad temper	❑	❑	Suicidal thoughts/attempt
❑	❑	Anxiety	❑	❑	Easily stressed	❑	❑	Seeing a therapist
❑	❑	Panic attacks	❑	❑	Lose control of emotions			
❑	❑	Other: _____						

Cardiovascular

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	High/Low BP	❑	❑	Irregular heartbeat	❑	❑	Heart valve problems
❑	❑	Anemia	❑	❑	Palpitations	❑	❑	Swelling of extremities
❑	❑	Fainting	❑	❑	Chest pain	❑	❑	Heart murmur
❑	❑	Blood cots	❑	❑	Poor circulation	❑	❑	High cholesterol
❑	❑	Other: _____						

Respiratory

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Cough	❑	❑	Bronchitis	❑	❑	Shortness of breath
❑	❑	Sleep apnea	❑	❑	Emphysema	❑	❑	Pain with deep breath
❑	❑	Asthma/wheezing	❑	❑	Pneumonia	❑	❑	Tightness in chest
❑	❑	Frequent cold/flu	❑	❑	Difficulty breathing while lying down			
❑	❑	Other: _____						

Genito-Urinary

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Pain on urination	❑	❑	Herpes	❑	❑	Unable to hold urine
❑	❑	Bedwetting	❑	❑	Sperm in urine	❑	❑	Urgency to urinate
❑	❑	Increased libido	❑	❑	Blood in urine	❑	❑	Decrease in urine flow
❑	❑	Decreased libido	❑	❑	UTI	❑	❑	Itchiness on genitals
❑	❑	Sore on genitals	❑	❑	Frequent urination	❑	❑	Erectile Dysfunction
❑	❑	Nighttime urination				❑	❑	Premature ejaculation
❑	❑	Incomplete feeling after urination				❑	❑	Ejaculation during sleep
❑	❑	STD _____	❑	❑	Other: _____			

Gastrointestinal

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Constipation	❑	❑	Black stool	❑	❑	Undigested food in stool
❑	❑	Diarrhea	❑	❑	Light colored stool	❑	❑	Burning sensation in anus
❑	❑	Blood in stool	❑	❑	Rectal pain	❑	❑	Foul smelling stool
❑	❑	Gas/Bloating	❑	❑	Indigestion	❑	❑	Chronic laxative use
❑	❑	Hemorrhoids	❑	❑	Abdominal cramps	❑	❑	Pain with defecation
❑	❑	Nausea/Vomiting	❑	❑	Hiccups	❑	❑	Belching
❑	❑	Bad Breath	❑	❑	Incomplete feeling after defecation			
❑	❑	Other: _____						

Skin & Hair

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Rashes	❑	❑	Dry skin	❑	❑	Itching
❑	❑	Eczema	❑	❑	Pimples	❑	❑	Tumors/Lumps
❑	❑	Hives	❑	❑	Moles	❑	❑	Change in hair/skin texture
❑	❑	Loss of Hair	❑	❑	Ulceration	❑	❑	Bleed or bruise easily
❑	❑	Other: _____						

Head, Eye, Ears, Nose & Throat

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Dizziness	❑	❑	Color blindness	❑	❑	Ear pain
❑	❑	Headache	❑	❑	Poor hearing	❑	❑	Sinus problems
❑	❑	Migraine	❑	❑	Cataracts	❑	❑	Runny nose
❑	❑	Concussions	❑	❑	Glaucoma	❑	❑	Sneezing
❑	❑	Facial pain	❑	❑	Spots in the eyes	❑	❑	Nasal Congestion
❑	❑	Sore throat	❑	❑	Night blindness	❑	❑	Peculiar Smells
❑	❑	Blurry vision	❑	❑	Eye pain	❑	❑	Sores in lips/tongue
❑	❑	Grinding teeth	❑	❑	Dry eyes	❑	❑	Nose Bleeds
❑	❑	Jaw clicks	❑	❑	Red eyes	❑	❑	Peculiar tastes
❑	❑	Gum problems	❑	❑	Itchy eyes	❑	❑	Change in vision
❑	❑	Teeth problems	❑	❑	Excessive phlegm	❑	❑	Ringing in ears
❑	❑	Excessive saliva	❑	❑	Other: _____			

Musculoskeletal/Neurological

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Knee pain	❑	❑	Hernia	❑	❑	Neck tightness/pain
❑	❑	Shoulder pain	❑	❑	Seizures	❑	❑	Muscle weakness
❑	❑	Hand/wrist pain	❑	❑	Tremors	❑	❑	Muscle pain/soreness
❑	❑	Back Pain	❑	❑	Numbness	❑	❑	Joint sprain
❑	❑	Hip Pain	❑	❑	Tingling	❑	❑	Joint disorders
❑	❑	Sciatica	❑	❑	Scoliosis	❑	❑	Paralysis
❑	❑	Other: _____						

Gynecological Is there a possibility you may be pregnant? ❑ Yes ❑ No

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
❑	❑	Painful periods	❑	❑	Irregular periods	❑	❑	Abnormal uterine bleeding
❑	❑	Infertility	❑	❑	Mastitis	❑	❑	Fibroids
❑	❑	Endometriosis	❑	❑	Breast lumps	❑	❑	Yeast infection/vaginitis
❑	❑	Vaginal discharge: Color: _____ Odor: _____						
❑	❑	Other: _____						

Menstruation: Start of last cycle: _____ PMS Symptoms: _____

Age of first period: _____ Number of days between periods: _____ Number of days of flow: _____

Menstrual flow: ❑ Heavy ❑ Light ❑ Clots ❑ Painful ❑ Spotting between periods

Menopause: Age of menopause: _____ Menopausal Symptoms: _____

Please mark any areas where you are experiencing pain, discomfort, or numbness on the diagram below.