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

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.