Acupuncture Intake and Health History

Name: _____ DOB: ___/___/_____ Age: ___ y.o.
Address: _____ Height: _____ Weight: ___ lbs.
City: _____ State: _____ Zip:_____
Mobile#: (____) _____-_____ Land Line#: (____) _____-_____
E-mail: _____
Occupation: _____ Employer:_____
Emergency contact:_____ Relation:_____ Ph#:_____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I request and consent to acupuncture treatments and other procedures within the scope of Traditional Chinese Medicine. Treatment methods may include, but are not limited to: acupuncture, electrical stimulation, manual therapies, cupping, moxibustion, Tui Na, Gua Sha, nutritional counseling, Chinese herbal medicine, and supplements. I will immediately notify my acupuncturist of any unpleasant effects associated with consuming herbs or supplements. I understand that acupuncture is generally a safe method of treatment, but that occasionally there may be some dizziness, bruising, soreness, pain, or tingling near the needle insertion sites, which could last for hours or days. Rare but serious risks of acupuncture include nerve damage and, in extremely rare cases, organ puncture. I am aware that cupping and Gua Sha treatments may leave visible marks on the skin that resemble bruising, and that these marks may last 7–10 days. I understand that, although this document outlines the significant risks of treatment, other side effects and risks may also occur.

CANCELLATION POLICY

Your treatment plan is designed to achieve optimal results; missing appointments may hinder your results. A $75.00 fee will be charged for missed or "no-show appointments. If a treatment package has been purchased, one session will be removed from your package for each missed appointment. A $50.00 fee will be charged for cancellations with less than 24 hours' notice.

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined in the Informed Consent and Cancellation Policies listed above.

Patient Signature: _____
Print Name: _____
Date: _____

*****Please continue to page 2.

Chief Concern(s)

Please list the condition(s) or symptom(s) you are seeking treatment for today:
_____
_____
_____

How long have you had this condition? _____ Date symptoms began:_____

How did this condition develop? (What caused it? / How did it start?)
_____
_____

How often do you notice symptoms of this condition (e.g., daily, weekly, occasionally, during specific activities)? _____

Overall, my condition has been getting (circle one): □better □worse □staying the same

Are there any known triggers or activities that aggravate your condition? _____
_____

Have you found anything that alleviates your symptoms or improves your condition? __
_____

Please indicate any diagnostic tests you've had: _____
_____

Have you had any previous treatments for these conditions? If so, what?
_____

Pain Assessment (if applicable)

On a scale of 1-10, how severe is your pain? (1= barely noticeable, 10= worst imaginable):
Area:_____, pain level ___ /10.
Area:_____, pain level ___ /10.

How would you describe your pain? (select all that apply):
□sharp □dull □achy □throbbing □stabbing □shooting □burning □tingling
□numbness pins & needles □cramping □stiffness □other:_____

Does your pain interfere with any of the following? Check all that apply:
□ sleep □ daily routines □ work □ sports □ recreation □ other:_____
Is your pain constant? □ Yes □ No | Does your pain come & go? □ Yes □ No

*Please continue to page 3.

MEDICAL HISTORY

Have you ever had acupuncture before? □Yes □No. If so, when? _____
Do you bruise easily? □ Yes □ No. | Do you bleed easily? □ Yes □ No

What was your most recent blood pressure reading? ____ /____ Date taken: _____

Do you have any diagnosed medical conditions (e.g., diabetes, hypertension, autoimmune disorders)? □ Yes □ No. If yes, please specify: _____
_____

Are you currently taking any prescription medications, over-the-counter drugs, or herbal supplements? □ Yes □ No. If so, please list: _____
_____

Have you had any surgeries or hospitalizations? □ Yes □ No. If so, for what?
_____
_____

Do you exercise? □ Yes □ No. If yes, how often?_____
Do you smoke? □ Yes □ No. If yes, how much? _____
Do you drink alcohol? □ Yes □ No. If yes, how often? _____
Do you use recreational drugs? □ Yes □ No. If yes, how often? _____
Do you have any infectious diseases? □ Yes □ No. If yes, please identify: _____
_____

Hours of sleep per night:____. Do you have difficulty falling asleep or staying asleep?
□ Yes □ No. If yes, please describe: _____
Do you wake feeling rested? □ Yes □ No
How is your energy level throughout the day?
□ Consistent □ Fatigued in the morning □ Fatigued in the afternoon □Fatigue all day
Other: _____

How would you describe your mood in general?
□ Stable □ Anxious □ Depressed □ Irritable □ Stressed □ Angry
Other: _____

How is your appetite? □ Good □ Poor □ Variable
Do you experience: □ Bloating □ Gas □ Constipation □ Diarrhea □ Heartburn
Please list any gastrointestinal disorders: _____

*Please continue to page 4.

For Women Only:

Do your periods occur on a regular schedule? □Yes □No □ N/A
Average length of cycle: _____ | # of days of menstrual bleeding: _____
Do you experience: □ cramps □ PMS □ heavy bleeding □ scanty cycles □ clotting
□ other:_____
Are you currently pregnant? □ Yes □ No. | Are you nursing? □ Yes □ No
Are you on birth control? □ Yes □ No. If yes, what kind? _____
Age of menopause (if applicable): _____ y.o.

INSURANCE INFORMATION (if applicable)

Name of Insurance Company _____ □HMO □PPO □EPO
Member ID# _____ Group # _____

<u>If using insurance, please provide a copy of both the front and back of your health insurance card.</u>

Is your injury work-related? □ Yes □ No.| Were you referred from the VA? □Yes □No.
Were you involved in an automobile accident? □ Yes □ No

- Please arrive 5-10 minutes early to allow time to settle in and relax before your treatment begins.
- Avoid coming on an empty stomach; eat something substantial within 1–2 hours before your appointment.
- Whenever possible, wear loose, comfortable clothing to help you stay comfortable during treatment.
- Please silence your cell phone while in the office and refrain from having phone conversations in the waiting room.

By signing below, I hereby certify that the information provided by me in this form is true, accurate, and complete to the best of my knowledge and belief. Furthermore, I authorize the treating provider to review and disclose my medical information to other healthcare providers as needed for treatment and healthcare operations.

Patient Signature: _____
Print Name: _____
Date: _____

You're all done! :)