Intake Form

Name_____ Date of Birth_____

Address_____ Social Security # _____

_____ Marital Status _____

Phone: Home _____ Referred By _____
Work _____
Cell _____ **Email** _____

Family Physician_____

What is your chief complaint?

_____

What medication are you taking for this condition? _____

What other medications are you currently taking? _____

Please list any vitamins you take daily: _____

Please list any herbs or formulas you take: _____

Have you had any emotional upsets that stand out to you? _____

Please circle if you have any of the following: Anxiety / Depression / Mood Swings / Other

Please list any emotional diagnosis you have received _____

Have you had any physical traumas of major importance? _____

Please list any hospitalizations or surgeries you have ever had:

_____

Do you have any other health complaints?

_____

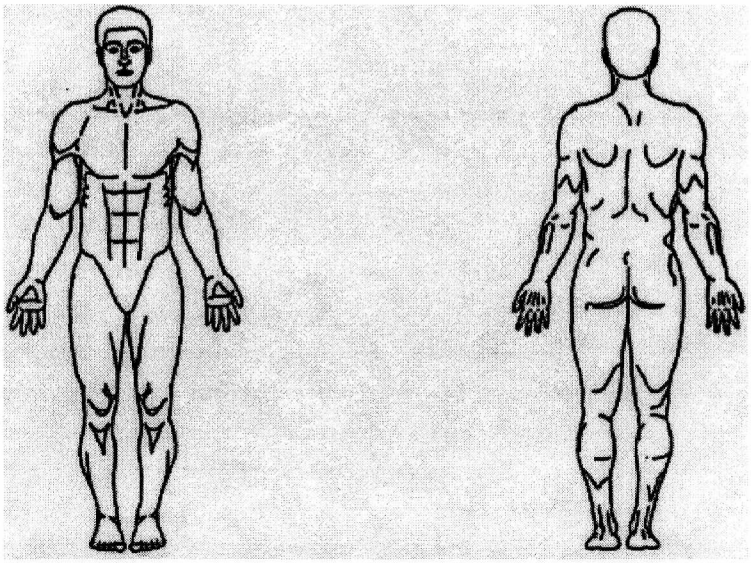
(Please circle) Do you or any persons you live with have: AIDS / Hepatitis / Tuberculosis / Any Infectious disease / none / other: _____

Do you smoke cigarettes? Yes / No If yes, how many per day: _____

Do you drink alcohol? Yes / No If yes, how much per day or week: _____

Currently, or in the past have you had any addictions? _____

On the following chart, please circle or mark with an "x" your painful areas:



Please describe your discomfort: (dull, sharp, burning, cold, stabbing, tingling, numbness etc.)

When did it start? Was there a particular event that began this discomfort?

Does this discomfort move around or does it stay in one place?

When do you get this: Time of day? Certain activity? Certain posture? Before or after meals? Etc.

How long does it last? _____

What makes it worse or better? _____

Is this condition affected by the time of day? Does it come on with a particular season?

How is your sleep? Please describe any problems. _____

_____

When you sweat, would you say you: sweat very little / sweat a lot / are average

Do you sweat at night? yes / no At night are you: hot / cold

How is your ability to taste food? just fine / diminished

How is your thirst? Are you often thirsty? _____

Do you prefer hot or cold drinks? _____

Would you describe your body temperature as either hot or cold? _____

How is your appetite: Normal / Light / Excessive / Other: _____

Regarding urination: (you may circle more than one choice) is it typically: normal quantity / slight / excessive / light / dark / clear / frequent / infrequent

How often do you move your bowels? _____

Are your bowel movements normal, loose or constipated? _____

Do you ever notice any blood associated with your bowel movement? _____

Do you exercise? Yes / No How Often: _____ What do you do: _____

_____

For Women:

Are you pregnant? Or is it possible that you are? _____

Number of children: _____ their ages: _____

Number of miscarriages: _____

Vaginal discharge? Yes / No If yes, please circle: clear / white / yellow / thin / thick

With regards to your menstrual cycle:

Is your cycle regular? Yes / No How many days in your cycle _____

The color of menstruation: light / dark / bright red (please circle) or other: _____

_____

Is your menstruation heavy / light / normal (please circle) or other _____

Is your menstruation painful? Yes / No /Other: _____

Is there clotting associated with your menstruation? _____

Family History

Please provide any information about your immediate family members:

NAME:	RELATION	PAST & PRESENT HEALTH PROBLEMS

Have you had acupuncture before? _____ When: _____

Do you have any other health concerns you would like to address?

_____

Do you have any particular questions or concerns you would like answered before we begin?

_____

ACUPUNCTURE CONSENT FORM

"Acupuncture" means the stimulation of a certain point of points on or near the surface of the body by the insertion of the special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of the physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at the acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning artemisia alone or artemisia formations).

The potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.

The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

"With this knowledge, I voluntarily consent to the above procedures."

_____	_____
Printed Name	Patient Signature
_____	_____
Witness	Date