

Patient Name _____

Date _____

General Information

Address _____ City _____ State _____

Home Phone _____ Occupation _____ Zip _____

Work Phone _____ Mobile Phone _____ SS# _____ Date of Birth _____

Email Address

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails Yes No

Texts Yes No

Mail Yes No

Emergency Contact _____ Relationship _____ Phone _____

Have you had Acupuncture or Oriental medicine before? Yes No Family Physician _____ Phone _____

What was your experience? Very good Good No change Married Partner Divorced Widowed Single

Are you presently under a doctor's care? Yes No Who and what for? _____

Are there any other therapies which you are involved in? Yes No Who and what for? _____

Insurance Information

Insurance Company _____ Phone _____ Date Called _____

ID # _____ Co-Pay \$ _____ Covered % _____

Visit # _____ Deductible Amount _____

Contact Name _____ Referral Yes No

Focus

What is the primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities? Work Standing Sexually Other
 Sleep Emotional Recreation
 Walking Relationships Bending
 Sitting Social Life Stretching

What have you done about this? _____

Are you interested in: Pain Relief Holistic Health Stress Relief Other
 Preventative Care Stretching/Yoga Herbal Therapy
 Oriental Nutrition Maintenance Care

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.): _____

List exercise and sport activities you have been or are currently involved in: _____

Do you have any allergies? Yes No If so, to what?

Do you take medication? Yes No If so, what types and how often?

Do you take supplements? Yes No If so, what types and how often?

Please indicate if you or any family members have or had any of the following conditions:

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Drug reaction	<input type="checkbox"/> Mental breakdown	<input type="checkbox"/> Gonorrhea/Herpes	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Jaundice	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hypo/hyper thyroid
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Parasites	<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Premature graying
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Measles	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Obesity	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Cancer	

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When? Do you have a low point during the day? Yes No When?

What are your indulgences?

What are your hobbies/pleasures?

Female Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How long? _____

PMS Clotting Vaginal sores Vaginal pain Discharge Other _____

Male Concerns

Testicle pain Penis pain Penis sores Discharge Premature ejaculation Nocturnal emission Impotence

Other _____

Signs/Symptoms

<input type="checkbox"/> Abdominal pain/distention	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Muscle cramps/pain	<input type="checkbox"/> Sinus pressure
<input type="checkbox"/> Abuse survivor	<input type="checkbox"/> Dark stools	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Skin fungal infection
<input type="checkbox"/> Acid regurgitation	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Hiccup	<input type="checkbox"/> Neck/shoulder pain	<input type="checkbox"/> Spots in eyes
<input type="checkbox"/> Acne	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Night sweat	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dizziness/vertigo	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Dry throat/mouth	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Numbness	<input type="checkbox"/> Sudden energy drop
<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Intestinal pain/cramps	<input type="checkbox"/> Odorous stools	<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Ear aches	<input type="checkbox"/> Irritable	<input type="checkbox"/> Pain upon urination	<input type="checkbox"/> Teeth/gum problems
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Enlarged thyroid	<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Peculiar tastes	<input type="checkbox"/> Ulcerations
<input type="checkbox"/> Breast lump/pain	<input type="checkbox"/> Eye pain/strain/tension	<input type="checkbox"/> Itchy skin	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Upper back pain
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Excessive phlegm	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Urgent urination
<input type="checkbox"/> Chest pains	Color of _____	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Chills	<input type="checkbox"/> Excessive saliva	<input type="checkbox"/> Laxative use	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Wake to urinate
<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Limited range of motion	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Weight loss/gain
<input type="checkbox"/> Concussion	<input type="checkbox"/> Fever	<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Rash	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Confusion	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Redness of eyes	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Gas/belching	<input type="checkbox"/> Migraine	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Cough	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Short temper	_____
	<input type="checkbox"/> Headache	<input type="checkbox"/> Mucus in stools	<input type="checkbox"/> Shortness of breath	_____

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

- No Pain Moderate pain Severe pain Terrible pain

Sleeping

- No problem Disturbed Very disturbed Cannot sleep

Work - Can do:

- Usual work 50% of work 25% of work No work

Frequency of pain

- 25% of time 50% of time 75% of time 100% of time

Travel

- No problem Moderate pain on trips Severe pain

Recreation - Can do:

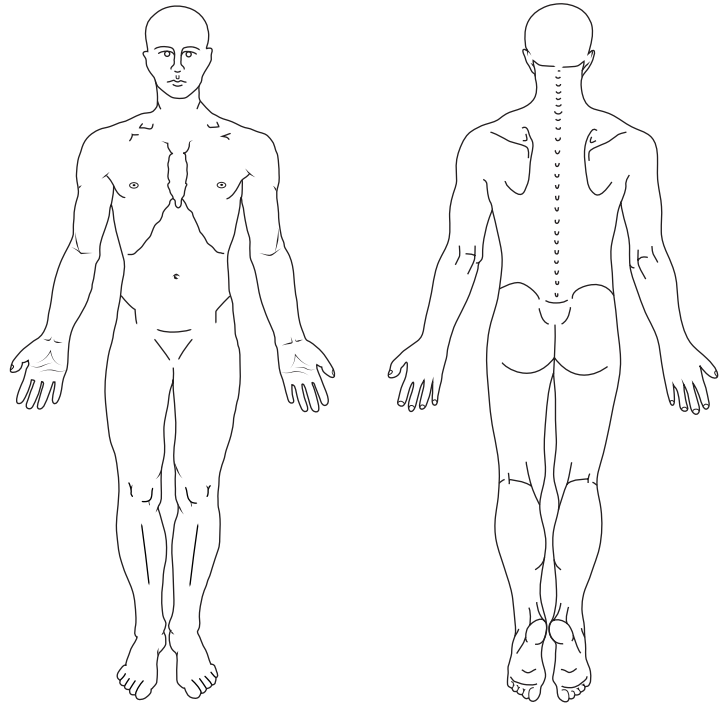
- All activities Some activities No activities

Walking

- Can walk fine Pain after 1/2 mile Cannot walk

Sitting

- No pain sitting Some pain while sitting Cannot sit



Pain Key

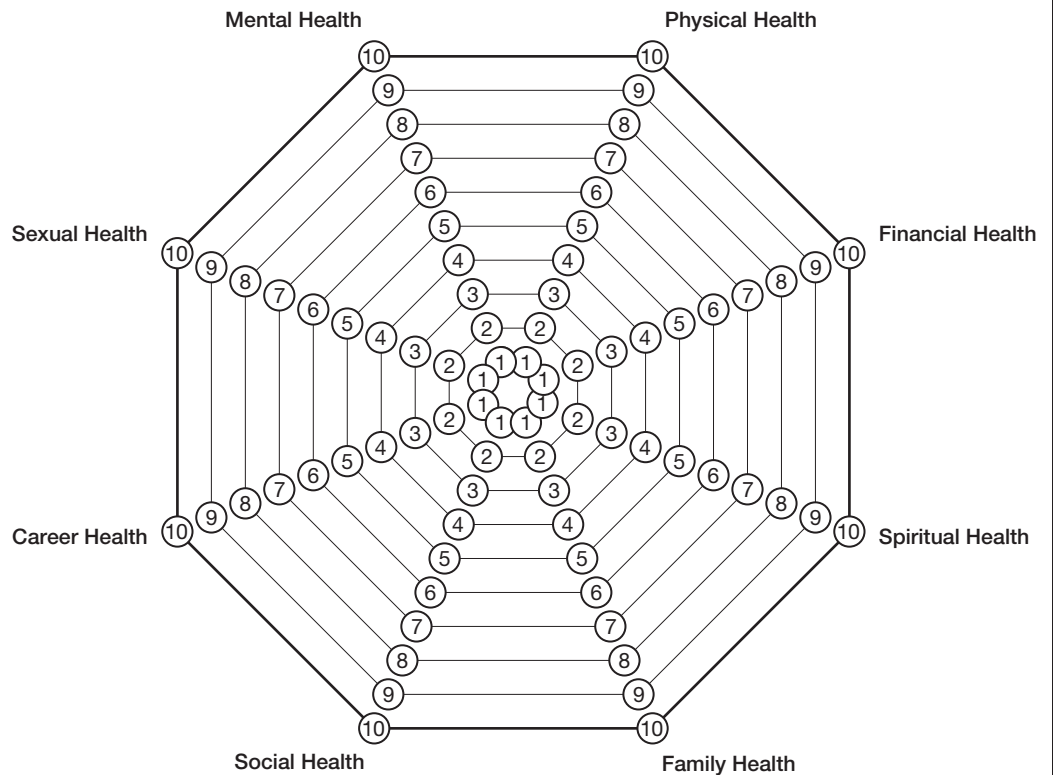
- | | | | | |
|---------|----------|----------------|---------|----------|
| Ache | Numbness | Pins & Needles | Burning | Stabbing |
| ^ ^ ^ ^ | == == | 0 0 0 0 | X X X X | /// / |

Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

- 1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

- not committed 1 2 3 4 5 6 7 8 9 10 very committed

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____