# ACUPUNCTURE CLIENT INFORMATION

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ E-mail _____ Work Phone _____

Occupation _____ Person responsible for your account _____

Emergency Contact _____ Phone _____

Whom should we thank for referring you here? _____

☐ Yes ☐ No Have you received acupuncture therapy before? When? _____ With Whom? _____

☐ Yes ☐ No Have you received Chinese herbal medicine? When? _____ With Whom? _____

What is the reason for today's visit? _____

How long have you had this condition? _____

Is it getting worse? ☐ Yes ☐ No Does it bother your: ☐ Sleep ☐ Work ☐ Other (explain) _____

_____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Are you under the care of a physician now? ☐ Yes ☐ No Who is your physician? _____

Other concurrent therapies? _____

## Health Insurance/Medicare Insurance

Insurance Company _____ Policy # _____ Phone _____

Address _____ City _____ State _____ Zip _____

Medicare Insurance _____ Policy # _____ Phone _____

Address _____ City _____ State _____ Zip _____

## Family Medical History

| | | | | |
|---|---|---|---|---|
| ☐ Allergies | ☐ Asthma | ☐ Cancer | ☐ Heart Disease | ☐ Seizures |
| ☐ Arteriosclerosis | ☐ Alcoholism | ☐ Diabetes | ☐ High Blood Pressure | ☐ Stroke |

## Your Past Medical History

Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ Emphysema | ☐ Pacemaker | ☐ Rheumatic Fever | ☐ Tuberculosis |
| ☐ Alcoholism | ☐ Epilepsy | ☐ Pleurisy | ☐ Scarlet Fever | ☐ Typhoid Fever |
| ☐ Allergies | ☐ Goiter | ☐ Pneumonia | ☐ Seizures | ☐ Ulcers |
| ☐ Appendicitis | ☐ Gout | ☐ Polio | ☐ Stroke | ☐ Venereal Disease |
| ☐ Arteriosclerosis | ☐ Hepatitis | ☐ Major Trauma (Car, Fall, Etc. - Specify) | ☐ Surgery (Specify) | ☐ Whooping Cough |
| ☐ Asthma | ☐ Heart Disease | | _____ | ☐ Other (Specify) |
| ☐ Birth Trauma | ☐ Herpes | _____ | _____ | _____ |
| (your own birth) | ☐ High Blood Pressure | _____ | _____ | _____ |
| ☐ Cancer | ☐ Measles | _____ | _____ | _____ |
| ☐ Chicken Pox | ☐ Multiple Sclerosis | _____ | _____ | _____ |
| ☐ Diabetes | ☐ Mumps | _____ | ☐ Thyroid Disorders | _____ |

## Medications/Supplements

List any medications or supplements you are currently taking: (Continue on back if necessary.)

| Medication | Dosage | Reason | How long | Prescribed by | Date of last checkup |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

## Your Diet

Appetite ☐ Low ☐ High

☐ Coffee
☐ Soft Drinks

☐ Artificial Sweetener

☐ Sugar
☐ Salty Food

☐ Thirst for water:
# glasses per day _____

## Average Daily Menu

| Morning | Snack | Noon | Snack | Evening | Snack |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## Your Lifestyle

☐ Alcohol
☐ Tobacco
☐ Marijuana

☐ Street Drugs
☐ Stress
☐ Occupational Hazards

Regular Exercise:
Type_____ Type_____
Frequency _____ Frequency _____

## General Symptoms

☐ Poor appetite
☐ Heavy appetite
☐ Strongly like cold drinks
☐ Strongly like hot drinks
☐ Recent weight loss/gain

☐ Poor sleep
☐ Heavy sleep
☐ Dream-disturbed sleep
☐ Fatigue
☐ Lack of strength

☐ Bodily heaviness
☐ Cold hands or feet
☐ Poor circulation
☐ Shortness of breath
☐ Fever

☐ Chills
☐ Night sweats
☐ Sweat easily
☐ Muscle cramps
☐ Vertigo or dizziness

☐ Bleed or bruise easily
☐ Peculiar taste (describe)
_____
_____
_____

## Head, Eyes, Ears, Nose, Throat

☐ Glasses
☐ Eye strain
☐ Eye pain
☐ Red eyes
☐ Itchy eyes
☐ Spots in eyes
☐ Poor vision
☐ Blurred vision

☐ Night blindness
☐ Glaucoma
☐ Cataracts
☐ Teeth problems
☐ Grinding teeth
☐ TMJ
☐ Facial pain
☐ Gum problems

☐ Sores on lips/tongue
☐ Dry mouth
☐ Excessive saliva
☐ Sinus problems
☐ Excessive phlegm
Color of phlegm
_____
☐ Recurrent sore throat

☐ Swollen glands
☐ Lumps in throat
☐ Enlarged thyroid
☐ Nose bleeds
☐ Ringing in ears
☐ Poor hearing
☐ Earaches
☐ Headaches

☐ Migraines
☐ Concussions
☐ Other head or neck problems
_____
_____
_____
_____

## Respiratory

☐ Difficulty breathing when lying down
☐ Shortness of breath

☐ Tight chest
☐ Asthma/Wheezing

☐ Cough
Wet or Dry?_____
Thick or Thin? _____

Color of phlegm
_____
_____

☐ Coughing blood
☐ Pneumonia

## Cardiovascular

☐ High blood pressure
☐ Blood clots

☐ Low blood pressure
☐ Fainting

☐ Chest pain
☐ Difficulty breathing

☐ Tachycardia
☐ Heart palpitations

☐ Phlebitis
☐ Irregular heartbeat

## Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Acid regurgitation
☐ Gas
☐ Hiccup
☐ Bloating
☐ Bad breath
☐ Diarrhea
☐ Constipation
☐ Laxative use
☐ Black stools
☐ Bloody stools
☐ Mucous in stools
☐ Intestinal pain or cramping
☐ Itchy anus
☐ Burning anus
☐ Rectal pain
☐ Hemorrhoid
☐ Anal Fissures
Bowel movements:
Frequency _____
_____
Color _____
_____
Texture/Form _____
_____
_____
Odor _____
_____

## Musculoskeletal

☐ Neck/shoulder pain
☐ Muscle pain
☐ Upper back pain
☐ Low back pain
☐ Joint pain
☐ Rib pain
☐ Limited range of motion
☐ Limited use
☐ Other (describe)
_____

## Skin and Hair

☐ Rashes
☐ Hives
☐ Ulcerations
☐ Eczema
☐ Psoriasis
☐ Acne
☐ Dandruff
☐ Itching
☐ Hair loss
☐ Change in hair
☐ Change in skin texture
☐ Fungal infections
Other hair/skin problems
_____
_____

## Neuropsychological

☐ Seizures
☐ Numbness
☐ Tics
☐ Poor memory
☐ Depression
☐ Anxiety
☐ Irritability
☐ Easily stressed
☐ Abuse survivor
☐ Considered/attempted suicide
☐ Seeing a therapist
Other (specify) _____
_____
_____

## Genito-urinary

☐ Pain on urination
☐ Frequent urination
☐ Urgent urination
☐ Blood in urine
☐ Unable to hold urine
☐ Incomplete urination
☐ Venereal disease
☐ Bed wetting
☐ Wake to urinate
☐ Increased libido
☐ Decreased libido
☐ Kidney stone
☐ Impotence
☐ Premature ejaculation
☐ Nocturnal emission

## Gynecology

☐ Age menses began
_____
Length of cycle
(day I to day I)
_____
☐ Duration of flow
_____
☐ Irregular periods
☐ Painful periods
☐ PMS
☐ Vaginal discharge
(color) _____
_____
☐ Vaginal sores
☐ Vaginal odor
☐ Clots
☐ Breast lumps
# Pregnancies _____
# Live births_____
# Premature births_____
Age at Menopause _____
Date of last PAP
_____
Date last period began
_____

## Personal Inventory

How do you FEEL about the following areas of your life? Please check the appropriate boxes and indicate any problems you might be experiencing

| | Great | Good | Fair | Poor | Bad | Your Comments |
|---|---|---|---|---|---|---|
| Significant Other | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Diet | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Sex | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Self | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Work | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Exercise | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Spirituality | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |

## Other information you would like to report/may be relevant to your medical history:

_____

_____

_____

PEAK PERFORMANCE
HOLISTIC THERAPIES

# INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I _____ hereby agree and consent to the performance of acupuncture and other Oriental Medicine procedures. I understand that such procedures may include, but are not limited to, acupuncture, moxibustion, cupping and gua-sha (dermal friction technique), Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling based on traditional Chinese medical theory.

**Acupuncture** is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments.

**Moxibustion** is the application of indirect heat by burning a stick of compressed Folium Artimesiae Vulgaris, commonly known as Mugwort, over acupuncture points and channels.

**Cupping** utilizes round suction cups over a large muscular area (such as the back) to enhance blood circulation to the designated area.

**Tui-Na** is a form of Chinese body treatment (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the site of treatments on the day of, or the day following the treatment.

I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, or hematoma which may occur at the site of insertion and may last a few days. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained or removed.

I am relying on the Peak Performance practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interest. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

I state that I do not have the following conditions: bleeding disorders, pacemaker, epilepsy, local infections; nor am I currently taking anti-coagulants. I also state that I am not pregnant at this time. If any of the proceeding conditions apply to me I have listed them here: _____

_____

By voluntarily signing below I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions, and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present conditions and for any future condition(s) for which I seek treatment.

_____

Date | Print Name | Signature of Patient (or Guardian if under 18 years of age)