

Appointment Date: \_\_\_\_\_

### I General Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Married Single Partner Divorced Widowed Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Referred By \_\_\_\_\_

Family Physician \_\_\_\_\_ Contact # \_\_\_\_\_ May we contact them? Y/N \_\_\_\_\_

Have you had Acupuncture or Oriental medicine before? Y/N \_\_\_\_\_

Are you presently under a doctor's care? Y/N \_\_\_\_\_ Who and for what? \_\_\_\_\_

Are there any other therapies which you are involved? Y/N \_\_\_\_\_ Who and for what? \_\_\_\_\_

### II Insurance Information

Insurance Company \_\_\_\_\_ Contact # \_\_\_\_\_

Group/Plan # \_\_\_\_\_ Co-pay \$ \_\_\_\_\_ Visit # \_\_\_\_\_ Referral Y/N Covered % \_\_\_\_\_ Ded.(?) \_\_\_\_\_

Date called \_\_\_\_\_ Contact Name \_\_\_\_\_

### III Focus

What is your 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  Performance Care  Maintenance Care  Other  
 Preventative Care  Holistic Health  Stress Relief  
 Oriental Nutrition  Meridian Yoga  Herbal Therapy

What are your health goals? \_\_\_\_\_

List any past or future surgeries. \_\_\_\_\_

List any significant trauma. When did they occur? (auto accident, falls, emotional, sexual, etc...) \_\_\_\_\_

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

**IV Signs/Symptoms**

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

**V Female Concerns**

Date of last menstruation \_\_\_\_\_ Is your cycle regular? Y/N \_\_\_\_\_ Is your cycle painful? Y/N \_\_\_\_\_ Have you ever been pregnant? Y/N \_\_\_\_\_

Birth control? Y/N \_\_\_\_\_ How long? \_\_\_\_\_  PMS  Clotting  Vaginal sores  Vaginal pain  Discharge

**VI Medical History**

Do you have any allergies? Y/N \_\_\_\_\_ If so, to what? \_\_\_\_\_

Do you take medication? Y/N \_\_\_\_\_ If so what types and how often \_\_\_\_\_

Do you take supplements? Y/N \_\_\_\_\_ If so what types and how often \_\_\_\_\_

- Please indicate if you or any family members have or had any of the following conditions:
- Pneumonia
  - Tuberculosis
  - Hepatitis
  - Diabetes
  - Epilepsy
  - Kidney Stone
  - Drug reaction
  - Heart attack
  - Blood transfusion
  - Anemia
  - Arthritis
  - Obesity
  - Mental breakdown
  - Jaundice
  - Parasites
  - Measles
  - Mumps
  - Syphilis
  - Gonorrhea/Herpes
  - HIV/Aids
  - High/low blood pressure
  - Heart disease
  - Gout
  - Cancer
  - Mental illness
  - Hypo/hyper thyroid
  - Premature graying
  - Seizures
  - Multiple Sclerosis

Do you sleep well? Y/N

Do you dream? Y/N

Do you have a high point during the day? Y/N When? \_\_\_\_\_ Do you have a low point during the day? Y/N When? \_\_\_\_\_

What are your indulgences? \_\_\_\_\_

What are your hobbies/pleasures? \_\_\_\_\_

### VII Web of Wellness

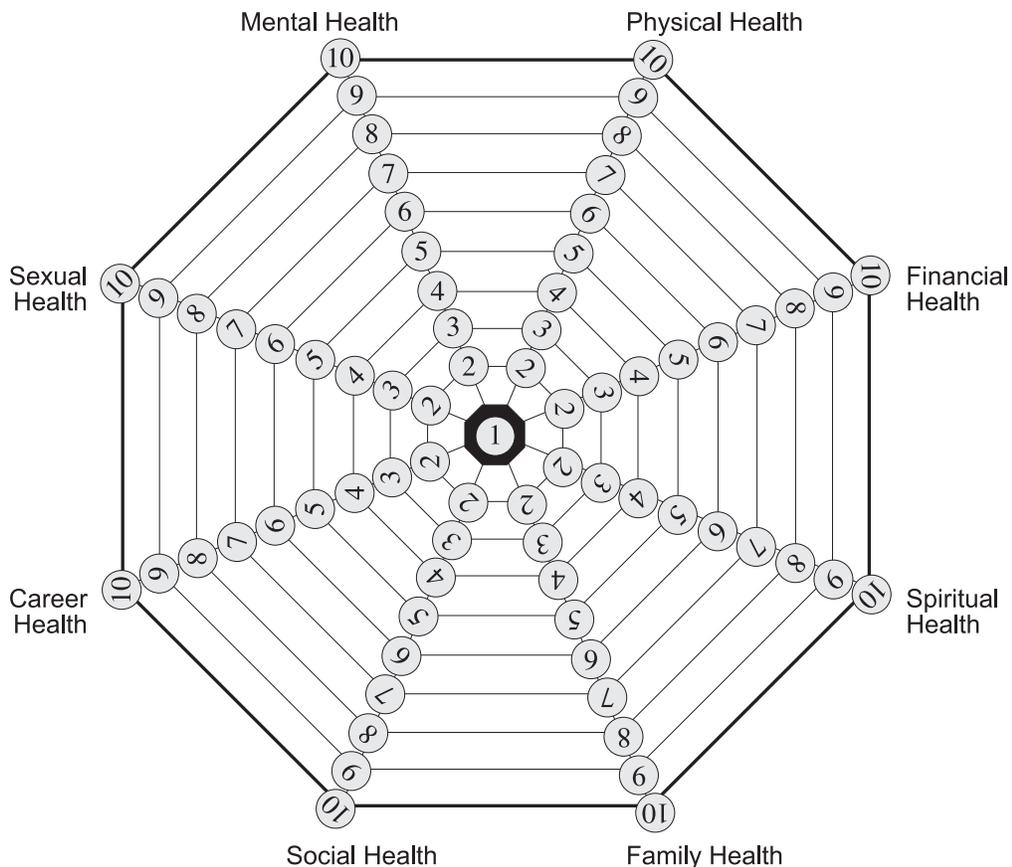
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



### VIII Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

**Pain intensity levels** (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain
---------	---------------	-------------	---------------

**Sleeping**

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep
------------	------------------	-------------------	--------------

**Work - Can do:**

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

**Frequency of pain**

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

**Travel**

No problem on long trips	Moderate pain on trips	Severe pain
--------------------------	------------------------	-------------

**Recreation - Can do:**

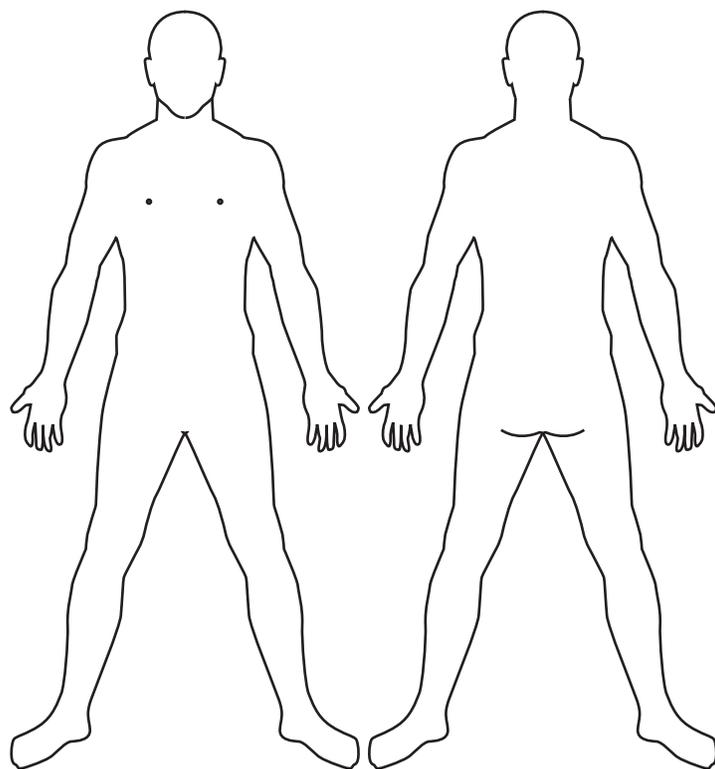
All activities	Some activities	No activities
----------------	-----------------	---------------

**Walking**

Can walk any distance	Pain after 1/2 mile	Cannot walk
-----------------------	---------------------	-------------

**Sitting**

No pain sitting	Some pain while sitting	Cannot sit
-----------------	-------------------------	------------



## Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.



### Acute Care

Obvious symptoms and signs

Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

### Maintenance Care

Symptom and signs disappear

Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

### Wellness & Preventative Care

You feel great

Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

## Terms of Acceptance

When a client seeks acupuncture health care and I accept a patient for such care, it is essential for both to be working toward the same objectives.

Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood, and other body fluids. When this is done correctly, the body will have the capacity to obtain and maintain health and well-being.

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Acupoint stimulation:** The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

**Health:** A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

**Qi imbalance:** When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential

I do not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination I encounter non-acupuncture or unusual findings, I will advise you. If you desire advice, diagnosis or treatments of those findings, I will recommend that you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help to facilitate healing and a potentially lead to a full expression of your body's innate wisdom.

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 on this basis.

(Signature) \_\_\_\_\_ (date) \_\_\_\_\_