Abundant Life Acupuncture & Massage

To help us provide you with the best possible care, please fill out this form as accurately as you can. All the information provided here will be held in strictest confidence. Feel free to ask if you have any questions.

Name______________________________ Age______ Today's Date________________

Mailing Address________________________ City____________________ Zip________

Street Address________________________ Email______________________________

Sex_______ Marital Status_______ Birthdate____________ Work phone ( ) ________________

Employer______________________________ Cell phone ( ) ________________

Occupation______________________________ Home phone ( ) ________________

Height__________ Weight__________ Referred by ______________________________

Emergency Contact________________________ Relationship & Phone____________________

Have you received acupuncture therapy before?__________

Main Complaint

____

____

Please rate your current pain or discomfort on a scale of 1-10:
Very slight 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes it feel better?________________________ Worse?________________________

Who else have you seen for this condition?______________________________

Please sign here if I may contact them regarding your case______________________________

Medical History *(include dates).*
Major illnesses____

____

Occupational stress (chemical, physical, psychological) ______________________________

____

Exercise (please describe)____

Please circle any that apply: tobacco coffee black tea green tea soft drinks alcohol recreational drugs

How many glasses of water do you drink daily? __________ 8 oz. glasses

Diet: A.M.________________ Noon________________ PM________________

________________ ________________ ________________

________________ ________________ ________________

Snacks:

Family Medical History (circle) Diabetes Cancer High Blood Pressure Depression/Mental Disorder Hysterectomy Asthma Heart Disease Stroke Prostate/Kidney Disorders Alcoholism/Addiction

Personal Medical History – indicate dates

___________ cancer ___________hepatitis ___________high blood pressure &/or cholesterol

___________heart disease ___________rheumatic fever ___________ thyroid disease

___________diabetes ___________seizures ___________sexually transmitted disease

___________emotional disorder ___________other:_______________________________________

Surgeries (type and date):

Significant trauma (auto accidents, falls, natural disaster, etc.):

Significant dental work (type & date):

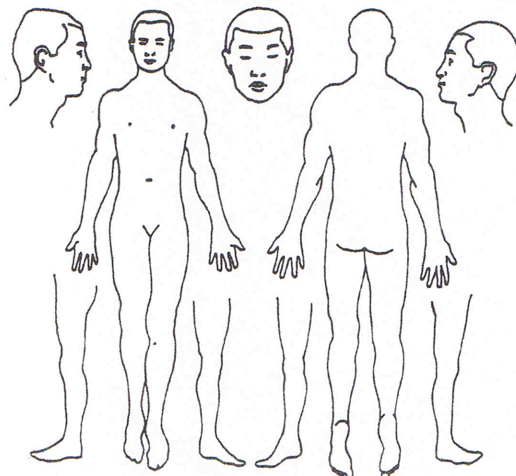
Allergies (drugs, chemicals, foods, & tests results):

Medications, vitamins, & herbs taken within the last 3 months---please include reason, date, & dosage:

Please tell us about the following areas of your life. Rank your feelings on a scale of 1 to 5 with 5 being the most favorable response:

Your relationship with		comments
your spouse or significant other	1 2 3 4 5	
your relationship with your family	1 2 3 4 5	
your diet	1 2 3 4 5	
your physical activity (exercise)	1 2 3 4 5	
your sexual relations	1 2 3 4 5	
your self image	1 2 3 4 5	
your job	1 2 3 4 5	

Indicate painful or distressed areas on figure(s):



Please check any of the following that recently/currently applies to you:

__Loose stools or diarrhea
__Flatulence
__Lack of appetite
__Feeling of retention of food in stomach
__Tendency to become obsessive in your work or relationships
__Indigestion
__Belching
__Anemia
__Bloating
__Nausea or vomiting
__Varicose veins
__Prolapsed organ
__HIV positive or AIDS
__Sweat easily
__Bruise easily
__Eating disorder

__Insomnia (what time?)________________
__Dream-disturbed sleep/nightmares
__Heart palpitations/racing
__Irregular heartbeat
__Restlessness
__Anxiety (attacks)
__Chest pain
__Easily startled

__Headaches/migraines (describe location+ sensation)_________________________________
__Arthritis
__Poor vision
__Spots before eyes/Night blindness
__Gallstones
__Difficult bowel movements
__Depression/ Indecisiveness
__High/low blood pressure
__Ringing in ears
__Shoulder or neck tension
__Hemorrhoids
__Fullness behind the ribs
__Cataracts
__Dizziness
__Sciatica
__Hepatitis
__Soft or brittle nails
__Eczema
__Shingles
__Herpes
__Impatience
__Easily irritated

__ Shortness of breath
__Sinus congestion/infections
__ Recent use of antibiotics
__Bronchitis
__ Emphysema
__ Cough
__ Weak voice
__ Asthma
__Sore throat
__ Sadness/Grief
__Constipation
__Nasal discharge: __Clear __White __Green ___Bloody ___Thick ___Thin and watery

Skin problems:____

__Hearing loss
__Edema or swelling
__Impotence
__Teeth/gum problems
__Low back pain/weakness
__Hair loss
__Urinary disorders
__Reduced sexual energy
__Weak knees
__Prostate disorders
__Osteoporosis
__Fearfulness

__Spontaneous sweating
__Dislike physical movement
__No energy to speak
__General physical weakness
__Lack of strength
__General fatigue

__Blurred vision
__Skin rashes
__Dry, brittle hair
Numbness (where)____
__Poor memory

__Aversion to cold
__Frequent clear urination
__Cold hands and feet
__Lack of thirst
__Easily chilled
__Desire for hot drinks

__Frequently thirsty
__Low-grade afternoon fever
__Hot hands and feet
__Dry throat
__Night sweats
__Red, flushed cheeks

Other____
____

Gynecological

Is there any possibility that you are pregnant? __Yes ___No Birth control________________________________

Pregnancies_______ # Births______ #Miscarriages______ # Abortions______ # Premature births________

Menstrual flow: ___Heavy ___Light ___Clots ___Painful Color of menses:_________________________________

No. of days between periods____________________________ Length of period________________________________

Date of last period______________ Date of last PAP___________________ PAP results__________________________

Age at first menses______________ ____Spotting between periods ____Vaginal sores____________________

PMS: ___Breast soreness ___Bloating ___Moodiness ___Irritability ___Cramps Other______________________

Perimenopausal: ___Skipped/irregular periods ___Hot flashes ___Moodiness ___Vaginal dryness

Menopause/age: ________ Hysterectomy/age and reason:____

____ Vaginal discharge ____ Breast lumps/cysts Endometriosis/When:_____________ Other______________________

Other:

How would you describe your overall emotional state/tendency?____

Please let us know if there are any other issues that you would like to discuss: _______________________________

____

For Your Information---please read and sign.

1) Only sterile, disposable needles are used. Treatment procedures include: Acupuncture (insertion of needles), Cupping (cups place on skin with a vacuum effect), Gua Sha (rubbing an area with a blunt instrument), Moxa (burning of moxa herb to warm acupoint), Herbs (pill, powder, tincture, paste, plaster, raw for internal or external use), and Massage (Swedish, Shiatsu, Tuina, Reiki, Touch for Health, Pain Neutralization Technique).

2) Occasionally you may get temporary discoloration of the skin or a small hematoma (a little bruise) after an acupuncture needle is removed. This is not a cause for concern---it will go away after a few days. Gentle pressure applied to the site will stop any small amount of bleeding that is occurring under the skin. Potential risks (rare): nausea, loose bowel movements, abdominal cramping, pneumothorax, or slight aggravation of some symptoms existing prior to the acupuncture treatment before symptoms improve. After receiving an acupuncture treatment, you may feel a little light-headed. If so, please have a seat in the reception room or take a short walk around our building. In a few minutes, you will feel relaxed and clear-headed.

3) Herbal prescriptions and herbal patent medicines are intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.

4) Please do not wear cologne, perfume, or strongly scented lotion on the day of your appointment with us. Many of our clients are allergic or sensitive to them.

5) All fees for medical services are due at the time of each treatment unless other arrangements are made. If you need to cancel an appointment, please give 24 hours notice (48 would be kinder) to avoid being required to prepay for appointments.

I have read the above information. I hereby request to be treated with acupuncture and/or Chinese herbal medicine for my condition. I hereby release Lea H. Siebert from any and all liability that may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name______________________________ Signature________________________________ Date____________________

Parent Name ______________________________ Signature ________________________________ Date ____________________