Colleen Porter Acupuncture LLC
123 Amherst Street
Winchester, VA 22601

First Name: _____ Last Name: _____

Preferred Name: _____ Date of First Visit: _____

Email Address: _____

Mobile Phone: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Gender: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Guardian: _____

How did you hear about us? _____

CURRENT CONDITION(S)

List 3 concerns/complaints you would like to address in order of importance. Please include date(s) of onset.

_____

_____

_____

What makes your condition better? _____

What makes your condition worse? _____

Does your condition (check one)

□ Come & go □ Get worse throughout the day □ Stay constant throughout the day

What is your level of pain? (where 0 = no pain, 10 = extremely painful)

0 1 2 3 4 5 6 7 8 9 10

GENERAL HEALTH

Check any that applies to you and/or your family. Briefly describe.

□ Abdominal Pain _____
□ Asthma _____
□ Blood/Bleeding Disease _____
□ Bone/Joint Problems _____
□ Cancer _____
□ Cataracts _____
□ Diabetes _____
□ Epilepsy / Seizures _____
□ Eczema _____
□ Fainting _____
□ Fatigue _____
□ High Cholesterol _____
□ Hypertension _____
□ Heart Disease _____
□ Hepatitis _____
□ Lung Disorder _____
□ Psychological Disorders _____
□ OB/GYN problems _____
□ Stroke _____
□ Sexually Transmitted Disease _____
□ Skin Disorder _____
□ Thyroid condition _____
□ Muscular Disease _____
□ Numbness / Tingling sensation of limbs _____
□ Immunodeficiency Disorders _____

Skin (Check any that apply)

□ Dry / Itchy □ Moist / Clammy □ Burning sensation □ Changing moles or lumps
□ Frequent skin rashes □ Acne □ Easily bruised

Sweating (Check any that apply)

□ Night sweats □ Excess sweating during the day □ Rarely sweat

Circulation (Check any that apply)

□ Often feels cold □ Often feels too hot □ Cold hands and feet

Eyes (Check any that apply)

□ Dry Eyes □ Eye Pain □ Blurry vision □ Floaters

Nose (Check any that apply)

□ Runny nose □ Stuffy nose □ Frequent nose bleeds □ Sinus congestion

Chest (Check any that apply)

□ Wheezing □ Difficulty breathing □ Shortness of breath □ Persistent cough
□ Rattling sound when breathing □ Pain / Pressure at chest □ Coughing with Phlegm

Head (Check any that apply)

□ Headache □ Migraine □ Dizziness □ Trouble concentrating
□ Forgetfulness □ Vertigo

Throat (Check any that apply)

□ Sore throat □ Difficulty swallowing □ Hoarseness □ Pain when swallowing
□ Feeling of something being stuck

Bowels (Check any that apply)
□ Diarrhea □ Constipation □ Alternating diarrhea and constipation
□ Gas / Bloating □ Hemorrhoids Blood in stools

Urine (Check any that apply)

□ Frequent UTIs □ Dark color □ Strong smell Burning / Painful □ Blood in urine
□ Frequent urination during the day □ Frequent urination during the night

WOMEN

Are you pregnant? _____ If YES, how many weeks? _____

Start date of your last period? _____ Age at first period? _____

Birth Control: □ None □ Pill □ IUD □ Other

Menopause? □ Yes □ No If YES, at what age did Menopause start? _____

Are you on Hormone Therapy? □ Yes □ No

Menstrual and Premenstrual Symptoms (Check any that apply)

□ Cramps
□ Breast distention
□ Breast Pain
□ Low back pain/ache
□ Water retention
□ Mood changes
□ Missed Periods
□ Irregular Cycle
□ Bleeding between cycles
□ Clots
□ Heavy bleeding
□ Light / scanty bleeding
□ Migraines
□ Nausea
□ Vomiting
□ Bowel changes
□ Low / No libido
□ Hot flashes

Number of pregnancies and any complications (include c-sections): _____

_____

Number of deliveries: _____ Number of miscarriages: _____ Number of abortions: _____

MEN

Check any that applies:

□ Low / No Libido □ Erectile Dysfunction □ Premature ejaculation
□ Painful / Burning while urinating □ Mood swings □ Hormone Therapy

DIET/EXERCISE/LIFESTYLE

What is your appetite like? (Check any that apply)

□ Poor □ Excessive □ Lack of thirst □ Excessive thirst

Diet (Check any that apply & describe)

□ Vegetarian
□ Paleo Diet
□ Keto Diet
□ Gluten Free
□ Crash Diet
□ Food Allergies
□ Tends to skip breakfast
□ Tends to eat when emotionally upset
□ Tends to eat when emotionally upset
□ Have cravings
□ I feel happy with my current dietary habits
□ I wish to make dietary changes

_____

Typical day's food intake:

_____

_____

_____

_____

How often do you exercise? _____

What are your main stressors and what do you do to relax? _____

_____

_____

Do you smoke? If yes, how much? _____

Do you drink alcohol? If so, how much? _____

How much caffeine do you drink? _____

Do you use recreational drugs? Is so, what? _____

List any Medications / Herbal Supplements you are currently taking:

_____

_____

_____

_____

_____

List any Surgeries / Operations you have had with date(s):

_____

_____

_____

_____

Anything else you'd like to tell me that wasn't included? Any other questions?

_____

_____

_____

_____

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CONSENT (please initial)

Cancellation Policy

_____ I am aware of the Cancellation Policy.

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in Colleen's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee of $45.

Treatment Consent

ACUPUNCTURE: Acupuncture is performed by the insertion of needles through the skin. There may occasionally be adverse side effects such as local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

MOXABUSTION: Moxabustion is performed by burning the herb, mugwort, on or near the skin. It is done to warm an area or to redirect energy flow through an area. Because the mugwort is lit there is a risk of burning or scarring. Precautions are taken to minimize this risk including the application of a protective salve between the skin and the herb when it is placed directly on the skin.

CHINESE HERBS: Substances from the Oriental material medica may be recommended. Patients must follow the directions for administration and dosage. There may be certain adverse side effects such as changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. With any problems associated with these substances, patients should suspend taking them and call Colleen Porter as soon as possible.

ACUPRESSURE-MASSAGE: Acupressure-massage is used to modify to prevent pain perception and to normalize the body's physiological functions. There may be certain adverse side effects such as: muscle soreness or achiness and the possible aggravation of symptoms existing prior to treatment.

ELECTRO-ACUPUNCTURE: Electro-acupuncture may be administered with the acupuncture. There may be certain adverse side effects such as: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

_____ All of the above information has been explained to me and I have no further questions at this time. I consent to treatment with acupuncture and Oriental medicine. I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment that may be offered by a physician. I understand that I am free to refuse or stop treatment at any time.

I have received the Notice of Privacy Practices which describes how Colleen Porter may use and disclose my protected health care information to carry out treatment, payment of services, health care operations, and other purposes that are allowed by the law.

The practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices without notifying patients. A copy of the current privacy practices is available upon request at any time.

Patient Signature: _____ Date: _____

Patient Name (printed): _____