Abundant Life Well-Being LLC

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_____

Initial agreements/preference in this HIPPA Release Section

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

_____ I understand detailed HIPPA privacy explanation is available to me upon request.

This information may be released to _____:

____Spouse ____ Child(ren) ____ Other _____ Information is not to be released to anyone.

MESSAGES

Please call: ____ my work# ____ my home# ____ my cell # ____ Other_____

If unable to reach me:

____ You may leave a detailed message. ____ Please leave a message asking me to return your call. ____ Do not leave a message.

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):

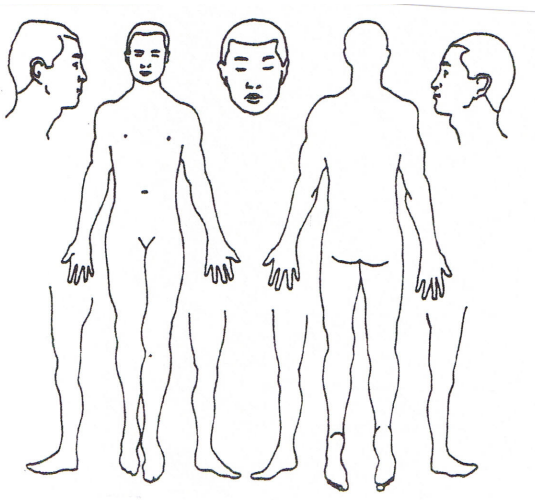
Allergies (drugs, chemicals, foods, & tests results):

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 about each topic (ie- if no "job", how do you feel about this status/area of your life?) on a scale of 1 to 5 with 5 being the most favorable response:

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

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

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

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

Skin problems:_____

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

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

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

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

__Frequently thirsty __Hot hands and feet __Night sweats
__Low-grade afternoon fever __Dry throat __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 _____