Acupuncture Intake Form **Today's Date:** _____________

Note: Information provided on this form is confidential.
It is very important the information given is complete and accurate to assist you properly in your healing process.

Please PRINT on the lines below

Last Name: ___________________________ First Name: _________________________

Date of Birth: ___/___/_____ Age: _____ Sex: ___M___F___ Height: _____ Weight: _____

Marital Status: (circle one) Married Single Widowed Divorced Separated

Address: ____

____

Email address: ____

Telephone (Home) ______________________ (Work/Cell) ____________________

Occupation: ____

Emergency Contact Person: ____

Relationship: _________________________ Telephone: _____________________

Primary Physician: _____________________ Physician's #: ___________________

How did you hear about us?

- ☐ Friend (please let us know who we may thank ______________________________)
- ☐ Relative (please let us know who we may thank ____________________________)
- ☐ Website (please list the site ____)
- ☐ Healthcare referral (please let us know who we may thank ____________________)
- ☐ Brochure (please let us know where you picked yours up ____________________)
- ☐ Other (please list ____)

Is this your first experience in Oriental Medicine and Acupuncture? ____ Yes ____ No

How do you feel about acupuncture? ______________________________________

What are you looking to treat with Traditional Chinese Medicine (please list in order of priority)?

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How long have you had this condition/these conditions?

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Onset: _____ Sudden _____ Gradual

If Pain is one of your concerns, please list your level of pain today _________________
(0 is no pain at all; 10 is the worst pain possible)

If Pain is one of your concerns, please list your average level of pain over the course of this last week ____________________
(0 is no pain at all; 10 is the worst pain possible)

Symptoms listed are relieved by: ____

Symptoms listed are worsened by: ____

Is the condition: ____ Getting worse ____ Getting better ____ Constant

____ Worse in the morning ____ Worse in the evening ____Interferes with activities

____ Interferes with sleep ____ Not a new condition (on and off situation)

What other treatments have you received for this condition? ______________________

____

____

What medications and/or supplements are you taking? __________________________

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Please list any surgeries or hospitalizations along with dates of occurrence:

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Please list any major events in your life (joys, sadnesses, traumas, etc.) which occurred before your symptoms began or for which you might be feeling the effects currently:

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Past Medical History

To the left of the boxes you check, please write “P” for past, “C” for current

- ☐ AIDS/HIV
- ☐ Hepatitis (please list type(s): ____)
- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergies (food, latex, antibiotics, please list: ______________________________)
- ☐ Anxiety
- ☐ Arthritis (please list type: ____)
- ☐ Asthma
- ☐ Bad Temper
- ☐ Birth Trauma
- ☐ Blurry Vision
- ☐ Cancer (type: ____)
- ☐ Cold Hands & Feet
- ☐ Concentration Difficult
- ☐ Cry Easily
- ☐ Depression
- ☐ Diabetes (____ DM Type 1 ____ DM Type 2 ____ Diabetes Insipidus)
- ☐ Drug Addictions (please list: ____)
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Dry Eyes
- ☐ Easy bleeding or bruising?
- ☐ Edema (please describe: ____)
- ☐ Emphysema
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Gall Bladder Disease
- ☐ Gastrointestinal Disorder (please describe: ________________________________)
- ☐ Glaucoma/Cataracts
- ☐ Headaches/Migraines (please list known triggers: ___________________________)
- ☐ Heart Disease
- ☐ Heart Palpitations

- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hypoglycemia
- [ ] Herpes
- [ ] Insomnia
- [ ] Joint Replacements
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Immune System (get sick easily)
- [ ] Lung Disease
- [ ] Lyme's Disease
- [ ] Lymph Nodes removed
- [ ] Memory loss
- [ ] Mental Illness (please describe: ____)
- [ ] Mood Swings
- [ ] Multiple Sclerosis
- [ ] Muscular Disorder
- [ ] Neurological Disorder
- [ ] Night Sweats
- [ ] Pacemaker
- [ ] Pain (please indicate if chronic or acute: ___________________________________)
- [ ] Panic Attacks
- [ ] Polio
- [ ] Rheumatic Fever
- [ ] Ringing in the Ears, Tinnitus
- [ ] Scarlet Fever
- [ ] Seasonal Allergies
- [ ] Seizures
- [ ] Sinus Infections
- [ ] STDs
- [ ] Thyroid Disorder
- [ ] TMJ/Teeth Grinding
- [ ] Tremors
- [ ] Tuberculosis
- [ ] Other:

Women Only

If still having a monthly cycle, how many days is your cycle? ______

Avg. length of blood flow? _________ Age at first menses? ________

Date of last menstrual cycle? ________ Are you currently pregnant? _____ Yes _____ No

Are you presently trying to get pregnant? ___ Yes ___ No Number of pregnancies? ______

Number of Miscarriages? ____ Number of abortions? ____ Number of live births? _____

Please check all boxes that apply to you

- ❏ Birth Control (please list type and how long been using: _________________________________)
- ❏ Breast Tenderness
- ❏ Clotting with Periods
- ❏ Fertility Concerns (please describe: ____)
- ❏ Heavy periods
- ❏ Endometriosis
- ❏ Hot flashes or Night Sweats
- ❏ Irregular Periods
- ❏ Ovarian Cysts/PCOS
- ❏ Painful Periods
- ❏ Perimenopausal
- ❏ Postmenopausal
- ❏ PMS
- ❏ Scanty Periods
- ❏ Spotting Between Periods
- ❏ Vaginal Discharge
- ❏ Vaginal Dryness
- ❏ Other:

Men Only

Please check all boxes that apply to you

- ❏ Birth Control (please describe: ____)
- ❏ BPH
- ❏ Ejaculation Concerns (please describe: ____)
- ❏ Erection Concerns (please describe: ____)
- ❏ Fertility Concerns (please describe: ____)
- ❏ Prostate Disease
- ❏ Testicular Pain or Masses
- ❏ Other:

Health Habits	Yes	No	If yes, how long & often per week?
Do you exercise?			
Do you smoke?			
Do you drink alcohol?			
Do you use recreational drugs?			
Have you ever been treated for any kind of dependence?			Explain:
Do you rely on coffee, soda or adrenaline drinks for an energy boost?			
Do you consume “diet” foods or drinks?			
Do you follow any diet modification? (vegetarian, vegan, gluten free, etc.)			Describe:
Do you tend to crave a certain type of food? (salty, sweet, spicy, sour, pungent)			
Does your weight fluctuate?			Describe:
Have you ever struggled with an eating disorder?			Describe:
Do you have regular bowel movements?			Describe your regular (times per day or week you have a BM):
Do you feel your body temperature runs hot or cold?			
Are you sexually active?			
Are you in a relationship?			How do you feel about your relationship?
Do you follow a spiritual practice?			Describe:

Health Habits	Yes	No	If yes, how long & often per week?
Do you have hobbies or interests?			Describe:
Do you sleep well? (Fall asleep easily, stay asleep, wake up rested)			If no, describe issue: Hours per night? Dream-Disturbed?
Do you wake feeling rested?			
Do you consider yourself a morning, afternoon or night person?			
Best energy level of day (0 is no energy, 10 is most energy)?			Time of day feel most energy?
Lowest energy level of day (0 is no energy, 10 is most energy)?			Time of day feel least energy?
Do you eat 3 meals a day?			
Are you satisfied with your level of libido?			
Do you enjoy your work?			
Do you spend time outside?			
Do you nap/take breaks/vacations when your body or mind needs rest?			If no, how do you relax?
Do you use a computer?			Hours per day?
When I make a mistake I am kind to and forgiving of myself?			Describe:
Do you criticize yourself or others?			Describe:
What is your level of motivation regarding your healing? (0 is not motivated at all, 10 is completely motivated)			Describe:

Food & Diet
Please describe your typical food intake - please include fluids consumed

Breakfast	Lunch	Dinner	Snacks
			Estimated water consumption in cups per day?

Please let us know what you expect to get out of your acupuncture treatment?

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Thank you so very much!

Print Patient Name: ____

WAIVER, RELEASE AND INDEMNITY

I am in agreement with the terms hereof in consideration of the services and programs offered by Natural Means, or by any person(s) associated with it. I understand that I do so at my own risk.

No warranty has been made to me concerning my health or safety with respect to my use of the facilities, services and programs.

I agree to waive any claim, course of action or liability of any kind against both Natural Means and The Healing Space, or any practitioners, if I choose to use the facilities, services or programs offered.

I will not hold Natural Means or The Healing Space, or any persons associated with same, liable for any injury occurring at Natural Means or The Healing Space, or resulting from any event, occurrence, or treatment at Natural Means or The Healing Space.

I understand all services are rendered on a cash, check or credit card basis. I agree to pay for each session at the time of the session; I also agree to pay for appointments concealed with less than the required 24-hour notice. In case my check returns, I agree to pay the $25.00 return check fee.

I have been evaluated by a western medical physician regarding my medical concerns and acknowledge that Natural Means and associated practitioners hereby advise that I should continue being seen by a western medical physician I trust at whatever intervals they recommend.

For female patients: I agree to let my practitioner know immediately if I suspect I am pregnant.

So that we may better serve you, we cannot hold appointments for patients arriving more than 15 minutes late, unless you are able to call and make arrangements to extend your session. You may be charged for a missed appointment.

Patient Signature: __________________________________ Date: ________________

I hereby authorize Natural Means to release information required in the course of my treatment, necessary for multi-practitioner therapy or to satisfy medical insurance claims.

Patient Signature: _________________________________ Date: ________________

Print Patient Name: ____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and, in rare cases, dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common, intended side effect of cupping. Unusual and unlikely risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses only sterile, disposable, vacuum sealed needles and maintains a clean and safe environment. Also, each acupoint used is cleaned before needle insertion.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. Because certain herbs are contraindicated for pregnancy, I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name: ____

Patient Signature: ______________________________ Date: __________

(Or Patient Representative) (Indicate relationship if signing for patient)