Acupuncture Intake

Name: ______________________________ Today's Date: ____________

Male Female Date of Birth __/__/__ Age ____ Height _____ Weight _____ SS# ____________

Marital Status: ____________ Will insurance be covering this visit? Y/N If yes, please give your card to the receptionist.

Home Address: ____
Street Address/P.O. Box City State Zip Code

Email address: ____________________ How did you hear about us? ____________

Home Phone #: ____________ Cell phone #: ____________ Occupation: ____________

Emergency Contact Name/ Phone #: ______________________________

Who is your primary care physician? ______________________________

What is your reason for your visit today? ______________________________

How long have you had this condition? ______________________________

What was the *initial* cause? ______________________________

What makes it *better*? ______________________________

What makes it *worse*? ______________________________

Have you ever had acupuncture? Y/ N Massage? Y/ N Chinese Herbal Medicine? Y/N

Your past medical history: Check all that apply.

Aids/ HIV
Alcoholism
Allergies
Asthma
Cancer
Chicken Pox
Diabetes
Emphysema
Gout
Heart Disease
Hernia
Herpes

High Blood Pressure
Measles
Multiple Sclerosis
Pace Maker
Pleurisy
Pneumonia
Rheumatic Fever
Scarlet Fever
Seizures
Stroke
Thyroid Disorder
Ulcers

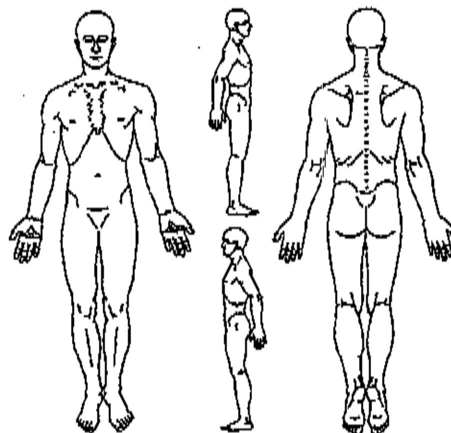
Other ____________

Surgeries/ Trauma ____________

Do you have any metal in your body? Y/ N

Musculoskeletal: Please check all that apply and indicate where your pain is on the diagram.

Neck/ Shoulder Pain
Back pain
Joint pain
Rib pain
Limited range of motion
Pain limiting daily activities
Other ____________



Please mark all that apply.

General Symptoms

Recent weight loss/ gain	Cold hands/ feet	Night sweat	Cold body temp.
Bleed or bruise easily	Muscle Cramps	Vertigo/ dizziness	Hot body temp.
Fatigue	Appetite strong/ weak	Sweat Easy	Poor sleep

Respiratory

Shortness of breath	Cough: wet or dry	Coughing Blood	Tightness in chest
Asthma/ wheezing	Color of phlegm_____________		

Gastrointestinal

Nausea	Diarrhea	Bowel movements:
Vomiting	Constipation	How many times per day ________
Acid regurgitation	Black stools	Color _________
Hiccup	Bloody stools	Texture (formed, loose, dry, etc.)
Bad breath	Mucous in stools	______________________________
Gas	Intestinal pain/ cramping	
Bloating	Hemorrhoid	

Genito-Urinary

Painful urination	Unable to hold urine	Frequent Urination	Wake to urinate
Incomplete urination	Kidney stone	Increased libido	Decreased libido
Nocturnal emission	Impotence		

Neuropsychological

Numbness	Tics	Seizures	Anxiety
Poor Memory	Irritability	Easily Stressed	Abuse survivor
Depression	Considered/ attempted suicide		

Skin and hair

Rashes	Eczema	Psoriasis	Acne
Itching	Fungal Infections	Dry skin or dandruff	

Gynecology

Irregular periods	PMS	Vaginal Discharge	Color: _________
Strong odor	History of miscarriage	Spotting	

Duration of flow: _____________ Length of Cycle: ______________ Does this fluctuate? ______

Date of last period: _________ # of pregnancies: ______ # of live births: _____ Age at menopause: ____

Other: ____

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me by the acupuncturist listed on intake paperwork.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping and gua sha, electrical stimulation, breathing techniques, exercise therapy, Chinese or western herbal medicine, nutritional counseling and neuromuscular therapy.

I have been informed that acupuncture is a safe method of treatment, but it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained or removed. Bruising is a common side effect from deep neuromuscular work, cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although the acupuncturist uses sterile disposable needles and maintains a clean and safe environment. Burns or scarring are potential risks of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements that may have been recommended are traditionally considered sage although some may be harmful in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, rashes and tingling of the tongue.

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

By voluntarily signing below I show that I have read this consent and have been told about the risks and benefits of acupuncture and other procedures and that I have had an opportunity to ask questions. I will not hold the acupuncturist or J.S. Chiropractic (Scott Chiropractic on Lake Loveland) liable for any injuries, accidents, conflicts or physical ailments that may occur after treatment. I understand that I will be financially responsible for all charges incurred by me, regardless of case type.

*I understand that there is a 24 hour cancellation policy and I will be responsible for $65.00 for failure to cancel or reschedule my appointment within the 24 hours of my scheduled appointment. Payment will be required within 14 days of missed appointment.

**I understand that J.S. Chiropractic is willing to bill qualifying insurance plans, however, if the reimbursement rate is lower than the cash rate for $65.00 per hour, I will be responsible for any difference.

Date: ______________________________

Patient Signature: ______________________________

Print Patient Name: ______________________________