

Appointment Date:

General Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____ SS# _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____

Have you had Acupuncture or Oriental medicine before? Yes No

Are you presently under a doctor's care? Yes No Who and for what? _____

Are there any other therapies which you are involved in? Who and for what? _____

Insurance Information

Insurance Company _____ Contact # _____

ID # _____ Co-pay \$ _____ Visit # _____ Referral Yes No Covered % _____

Date called _____ Contact Name _____ Deductable amount _____

Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

☐ Work	☐ Standing	☐ Sexually	☐ Other
☐ Sleep	☐ Emotional	☐ Recreation	_____
☐ Walking	☐ Relationships	☐ Bending	_____
☐ Sitting	☐ Social Life	☐ Stretching	_____

What have you done about this? _____

Are you interested in: ☐ Pain Relief ☐ Performance Care ☐ Maintenance Care ☐ Other

☐ Preventative Care ☐ Holistic Health ☐ Stress Relief _____

☐ Oriental Nutrition ☐ Meridian Yoga ☐ Herbal Therapy _____

What are your health goals? _____

List any past or future surgeries. _____

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) _____

List exercise and sport activities you have been or are currently involved in: _____

Signs/Symptoms

- | | | | | |
|---|---|---|---|---|
| ☐ Abdominal pain/distention | ☐ Coughing blood | ☐ Hemorrhoids | ☐ Mucous in stools | ☐ Seizures |
| ☐ Abuse survivor | ☐ Dark stools | ☐ Heart palpitations | ☐ Muscle cramps/pain | ☐ Seeing a therapist |
| ☐ Acid regurgitation | ☐ Decreased libido | ☐ Hiccup | ☐ Nasal congestion | ☐ Short temper |
| ☐ Acne | ☐ Depression | ☐ High blood pressure | ☐ Neck/shoulder pain | ☐ Shortness of breath |
| ☐ Asthma | ☐ Dizziness/vertigo | ☐ Impotence | ☐ Night sweat | ☐ Sinus pressure |
| ☐ Bad breath | ☐ Dry throat/mouth | ☐ Increased libido | ☐ Nocturnal emission | ☐ Skin fungal infection |
| ☐ Blood in stools | ☐ Diarrhea | ☐ Indigestion | ☐ Nose bleeds | ☐ Spots in eyes |
| ☐ Blood in urine | ☐ Ear aches | ☐ Intestinal pain/cramps | ☐ Numbness | ☐ Sweat easily |
| ☐ Blurry vision | ☐ Enlarged thyroid | ☐ Irritable | ☐ Odorous stools | ☐ Sore throat |
| ☐ Breast lump/pain | ☐ Eye pain/strain/tension | ☐ Itchy eyes | ☐ Pain upon urination | ☐ Sudden energy drop |
| ☐ Bruise easily | ☐ Excessive phlegm | ☐ Itchy skin | ☐ Peculiar tastes | ☐ Swollen glands |
| ☐ Chest pains | ☐ Color of | ☐ Joint pain | ☐ Poor appetite | ☐ Teeth/gum problems |
| ☐ Chills | ☐ Excessive saliva | ☐ Kidney stones | ☐ Poor circulation | ☐ Ulcerations |
| ☐ Cold hands/feet | ☐ Fatigue | ☐ Laxative use | ☐ Poor memory | ☐ Upper back pain |
| ☐ Concussion | ☐ Fever | ☐ Limited range of motion | ☐ Poor sleep | ☐ Urgent urination |
| ☐ Confusion | ☐ Frequent urination | ☐ Loss of hair | ☐ Premature ejaculation | ☐ Vomiting |
| ☐ Constipation | ☐ Gas/belching | ☐ Low back pain | ☐ Psoriasis | ☐ Wake to urinate |
| ☐ Cough | ☐ Grinding teeth | ☐ Migraine | ☐ Rash | ☐ Weight loss/gain |
| | ☐ Headache | ☐ Mouth sores | ☐ Redness of eyes | ☐ Wheezing |

Female Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How long? _____

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge

Medical History

Do you have any allergies? Yes No If so, to what? _____

Do you take medication? Yes No If so what types and how often _____

Do you take supplements? Yes No If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

- | | | | | |
|------------------------------------|---|--|---|--|
| ☐ Pneumonia | ☐ Drug reaction | ☐ Mental breakdown | ☐ Gonorrhea/Herpes | ☐ Cancer |
| ☐ Tuberculosis | ☐ Heart attack | ☐ Jaundice | ☐ HIV/Aids | ☐ Mental illness |
| ☐ Hepatitis | ☐ Blood transfusion | ☐ Parasites | ☐ High/low blood pressure | ☐ Hypo/hyper thyroid |
| ☐ Diabetes | ☐ Anemia | ☐ Measles | ☐ Heart disease | ☐ Premature graying |
| ☐ Epilepsy | ☐ Arthritis | ☐ Mumps | ☐ Gout | ☐ Seizures |
| ☐ Kidney Stone | ☐ Obesity | ☐ Syphilis | | ☐ Multiple Sclerosis |

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When? _____ Do you have a low point during the day? Yes No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

Web of Wellness

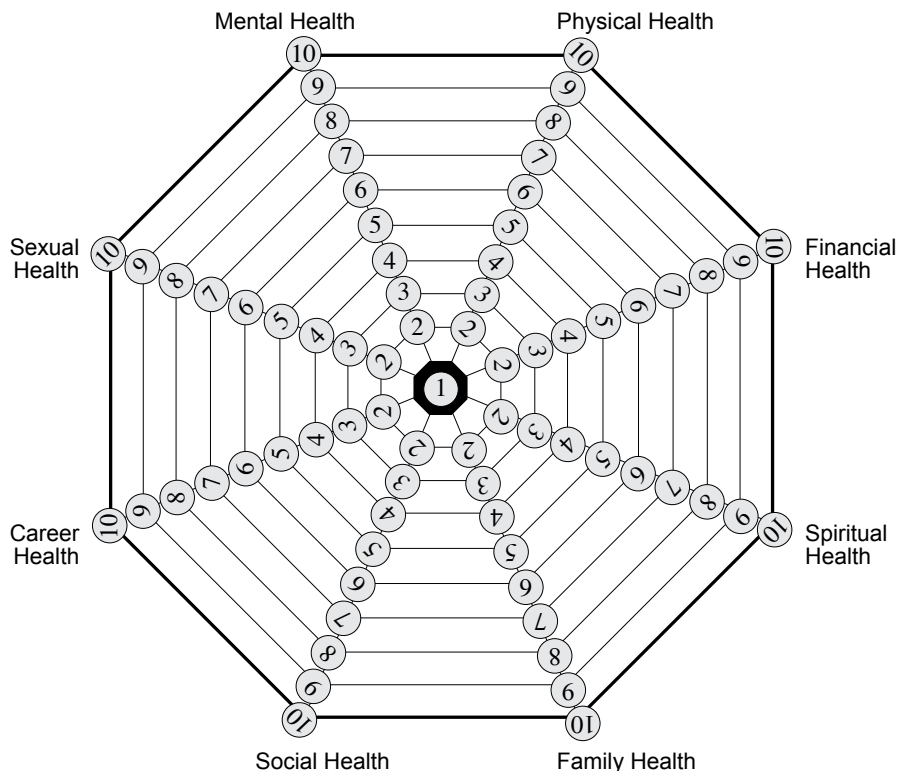
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain Moderate pain Severe pain Terrible pain

Sleeping

No problem Mildly disturbed Greatly disturbed Cannot sleep

Work - Can do:

Usual work 25% of work 50% of Work No work

Frequency of pain

25% of time 50% of time 75% of time 100% of time

Travel

No problem on long trips Moderate pain on trips Severe pain

Recreation - Can do:

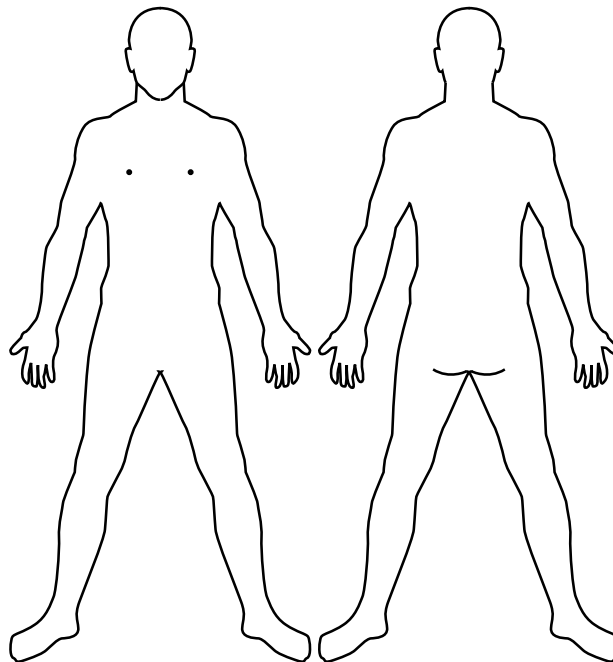
All activities Some activities No activities

Walking

Can walk any distance Pain after 1/2 mile Cannot walk

Sitting

No pain sitting Some pain while sitting Cannot sit



Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.



Acute Care

Obvious symptoms and signs

Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care

Symptom and signs disappear

Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care

You feel great

Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive medical system to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

(Signature) _____ (date) _____