JUBILATION ACUPUNCTURE
Acupuncture Intake Form

Chinese Medical Diagnosis requires complete and honest answers to questions pertaining to both the body and the spiritual/emotional state. Thank you for taking the time to fill out this form completely.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name________________________________Date of Birth___________________

Address____________________City_____________State_________Zip__________

Best phone # to contact you at:_______________ other phone #__________________

e-mail address____

In case of emergency contact____

Address (if different from above)____

Phone______________________ Relationship_____________________________

Please describe the reason for your visit today (Chief Complaint)__________________

____

Is it getting better, worse, or staying the same?________________________________

____

Are you, or have you been, treated for this problem with any other health professionals?

____

Has it been effective?____

What was your diagnosis?____

Are you taking any medication or herbal supplements? If so, which ones? (Add dosage if known)

____

MEDICAL HISTORY

Please circle any current health issue. For those diseases which are part of your health history, please note the year of the occurrence.

Allergies	Epilepsy	Polio
Anemia	Fatigue	Scarlet Fever
Appendicitis	Gout	Stroke
Arteriosclerosis	Heart Disease	Surgery (List):
Asthma	Hepatitis (A, B,C)	___________________
Bleeding Disorder	Hypoglycemia	___________________
Blood Pressure (Low or High)	Injuries	___________________
Cancer	Insomnia	Thyroid Disorder
Chicken Pox	Intestinal Parasites	Trauma (falls,
accidents)		
Diabetes	Multiple Sclerosis	Tuberculosis
Digestive Disorders	Mumps	Ulcers
Emotional Difficulties	Pacemaker	
Other________________		
Emphysema	Weight Loss or Gain	
______________________		

Do any of your family members suffer from: (Please list relationship to you)

Alcoholism	Arteriosclerosis	Heart Disease
Allergies (list)	Asthma	High Blood Pressure
______________	Cancer	Seizures
______________	Diabetes	Stroke

Which of the following are part of your lifestyle? How frequently do you engage in it?

Alcohol	Nicotine	Exercise
Coffee	Recreational Drug Use	Excessive Sugar

Do you usually eat three meals a day? ________Do you follow any particular diet?_____

On the scale of 1-10, how would you rate the level of stress in your life currently?

What is the level of stress in your life in general (1-10)?

How does stress affect you? (ie, more headaches, stomach pain, etc.)

Are there any other concerns you would like to address?

____

____

REVIEW OF SYSTEMS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! If you're currently experiencing the symptom circle it, if you have experienced it in your past, please put a check by it.

Head and Face
Headaches
Dizziness
Memory Loss
Other

Eyes
Blurry Vision
Eyelid Twitching
Floaters
Pain

Nose
Frequent Colds
Sinus Trouble
Bleeding

Mouth
Dental Problems
Gum Problems
Teeth Grinding/TMJ
Unusual Tastes
Other

Throat
Sore Throat
Hoarseness
Difficulty Swallowing
Dryness
Other

Respiration
Difficulty Inhaling
Difficulty Exhaling
Pain
Cough
Congestion
Shortness of Breath
Other

Heart and Chest
High Blood Pressure
Low Blood Pressure
Chest Pain
Chest Tightness
Difficulty Lying Down
Other

Circulation
Easy Bruising
Easy Bleeding
Cold Limbs-Hands or Feet
Reynaud's Syndrome

Gastrointestinal
Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain
Nausea
Diarrhea/Loose Stools
Constipation
Rectal Bleeding
Colon Problems

Urination
Frequent
Difficult
Painful
Nocturnal
Bleeding
Other

Skin
Acne
Dryness
Moles that Change
Lumps
Excessive Sweating
Night Sweats
Rarely Sweat
Other

Neurological
Nervousness/Anxiety
Tremors
Numbness or Tingling
Lack of Coordination
Nerve Pain
Other

Sleep
Insomnia
Drowsiness
Excessive Dreaming
Waking Easily
Other

Pain - Please Describe
____
____
____
____

Are there any other health concerns you'd like to address?
____
____

WOMEN

Are you, or could you be pregnant?____________ If so, how far along?____________

Number of pregnancies______ Births________ Abortions_____Miscarriages__________

What form of birth control do you use?____

Age of first menses_________ Age of menopause, if applicable____________________

Do you bleed between periods?____

Have you ever had any gynecological surgeries or any abnormal findings on any tests?__

____

Are your periods uncomfortable or painful, either emotionally or physically?__________

Are your periods:

Short (Less than 28 days)______Long (28+ days)______Varied______ Regular_______

Painful? If so, Before________ During________ After_________

Do you bleed heavily_________? Lightly________? Very little?__________

Do you have clots ?_______ Early in the cycle_______ or throughout?__________

Relative to the blood that comes from a wound, is your menstrual blood: The same color________More pale_______ Purple_______ More Red_______ More Brown_____

How many days do you bleed?___________

Do you have any of the following Pre-Menstrual Symptoms? (Emotions are not judged in Chinese Medicine, they are neither good nor bad. They are, however, important diagnostic tools. Please answer honestly.)

Irritability____ Depression______ Crying______ Rage______ Nausea_________

Cravings, and if so for what?______________Breast Tenderness______________

Any other symptoms around the time of your period?________________________

____

Do you have any other gynecological concerns or complaints?

MEN

Do you experience any of the following:

Reduced Libido________ Excessive Libido_________ Impotence_____________

Urinary Frequency_______ Premature Ejaculation__________ Discharge________

Genital/ Testicular pain___________

Any other concerns?____

I have provided correct and complete information to the best of my knowledge.

____________________________________ ______________________

Patient's or Guardian's signature Date

CONSENT TO TREATMENT

I hereby request and consent to the performance of Acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed Acupuncturist.

I understand that methods or treatments may include, but are no limited to, Acupuncture, moxIbustion, cupping, bloodletting, electrical stimulation, Tui Na massage, Gua Sha, Chinese or Western Herbal Medicine, nutritional counseling and/or supplementation, and magnets.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain and to treat certain diseases and dysfunction of the body. I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances of spontaneous miscarriage and pnuemothorax. There may be some bruising after cupping. I do not expect the Acupuncturist to be able to anticipate all risks and complications. I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturist feels at the time, based on the facts then known, is in my best interest.__________**initials**

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. I understand the some herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the Acupuncturist immediately.__________**initials**

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss any emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.

I agree to pay all charges incurred for services rendered and I agree to pay the full charge for any missed or forgotten appointments without 24- hour notice of cancellation. __________**initials**

By signing below, I agree to the above-named procedures. 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:

Patient's name:____DOB__________

Patient (or patient representative) signature:_______________________________Date______

Name of Licensed Acupuncturist: Brenda Terry, L.Ac, MAcOM

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.
Name of Patient:____

Patient's Representative:____

Relationship of Authority of Patient:____