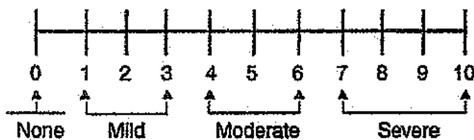
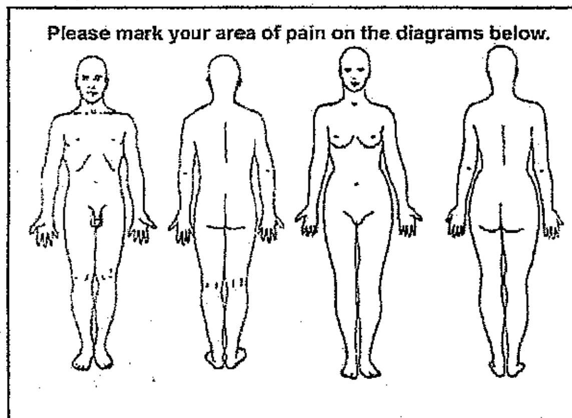
# Acupuncture Full Intake Form

Patient Name: ______________________________ Date: ____________________
Address: ______________________________ City: ____________ State: _____ Zip: ______
Phone: Home: ________________ Cell: ________________ Work: ________________
Date of Birth: ________________ Age: _______ Email: ______________________
Marital Status: ☐M ☐ S ☐ W☐ D Occupation: ______________________________
Emergency Contact's Name: ______________________________ Phone: ____________
Physician's Name: ______________________________ Phone: ____________
Height: ________ Weight: ______ Allergies: **(To Medications)**: ____________________
Insurance Carrier: ______________________________ Policy #: ____________
Telephone number: __________________ ☐ Insured ☐ Family member policy#: ____________

1. Acupuncture before? ☐ Yes ☐ No Have you eaten today? ☐ Yes ☐ No : time of last meal? _______
2. **What is the problem that brought you here today?** ______________________________
3. Was there a Physician's Diagnosis: ______________________________
4. Has there been anything that has ever been able to change your problem in any way? ☐ Yes ☐ No
   a. If yes, please describe. ______________________________
5. When did this problem first appear? ______________________________
6. Is it constant or does it come and go? ______________________________
7. If applicable, does the problem ever move? (For example, pain or spasms that occur in different joints or muscles at different times) ☐ Yes ☐ No
8. Do you have a history of chronic pain? ☐ Yes ☐ No
9. Type of Pain: ☐Dull ☐Aching ☐Stabbing ☐Throbbing
10. Are you experiencing pain right now? ☐ Yes ☐ No
11. If yes, what number best describes your pain? _______




12. What is the frequency of the pain? ☐ Continuous ☐ Intermittent
13. What makes your pain better? Please check all that apply: ☐Heat ☐Cold ☐Pressure ☐Rest ☐Movement ☐Massage ☐Other: ______________________________
14. Is your illness affected by seasonal changes? Please describe. ______________________________
15. Are there other problems you would like addressed? ______________________________
16. Have you had any surgeries? If yes, what type of surgery and when did you have it done?
______________________________________________________________
17. History of Significant Illness: **Self:** (Please include all past accidents, Childhood illnesses, and the date that they occurred, History of Vaccinations: Any reactions that you remember? Any unusual vaccinations?):
______________________________________________________________
______________________________________________________________
18. Do you have any infectious diseases? ☐ Yes ☐ No If Yes, Please List: ____________
19. **General Health (pleases check all that apply):** ☐Poor Appetite ☐Disturbed Sleep ☐Insomnia ☐Fatigue ☐Poor Coordination ☐Weight Gain ☐Cold Hands and Feet ☐Night Sweats ☐Cold Abdomen ☐Tremors ☐Large Appetite ☐Localized Weakness ☐Strong Thirst ☐Weight Loss ☐Fevers ☐Poor Balance ☐Bruise/Bleed Easily ☐Sweat Easily Cravings (explain below) ☐Chills ☐Sudden Energy Drop ☐Soft/Brittle Nails ☐Catch Colds Easily ☐Other (please specify): ______________________

# Acupuncture Full Intake Form

**20.Skin and Hair (please check all that apply):** ☐Rashes ☐Itching ☐Dandruff ☐Ulcerations ☐Redness ☐Eczema ☐Psoriasis ☐Hair Loss ☐Hives ☐Pimples ☐Recent Moles ☐Other (please specify)

______________________________

**21.Head, Eyes, Ears, Nose, Throat (please check all that apply):** ☐Dizziness ☐Eye Pain ☐Blurred Vision ☐Floaters ☐Spots in Eyes ☐Night Blindness ☐Ringing in Ears ☐Poor Hearing ☐Earaches ☐Headaches ☐Migraines ☐Recurrent Sore Throats ☐Sores on Lips orTongue ☐Dry Mouth/Throat ☐Bleeding Gums ☐Nosebleeds ☐Facial Pain ☐Jaw Clicking ☐Toothaches ☐Other (please specify) :

______________________________

**22.Cardiovascular (please check all that apply):** ☐Dizziness ☐Low Blood Pressure ☐High Blood Pressure ☐Irregular Blood pressure ☐Irregular Heart Beat ☐Fainting ☐Cold Hands/Feet ☐Chest Pain ☐Swelling of Hands/Feet ☐Blood Clots ☐Difficulty Breathing ☐Palpitations ☐Other (please specify) :

______________________________

**23.Respiratory (please check all that apply):** ☐Cough ☐Coughing Blood ☐Asthma ☐Bronchitis ☐Pneumonia ☐Coughing Phlegm ☐Pain with deep breath ☐Shortness of Breath ☐Nasal Congestion ☐Difficulty breathing when lying down ☐Other (please specify) : ______________________________

**24.Gastrointestinal/Abdominal issues (please check all that apply):** ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Gas ☐Bloating ☐Belching ☐Abdominal Pain/Cramps ☐Indigestion ☐Heartburn/Reflux ☐Retention of Food in Stomach ☐Lack of Appetite ☐Excessive Appetite ☐Rectal Pain ☐Black Stools ☐Blood in Stool ☐Hemorrhoids ☐Bad Breath ☐Sensitive Abdomen ☐Chronic Laxative Use ☐Other (please specify):______________________________

**25.Urinary and Genital (please check all that apply):** ☐Pain on Urination ☐Frequent Urination ☐Blood in Urine ☐Urgency to Urinate ☐Unable to Hold Urine ☐Kidney Stones ☐Decrease in Urine Flow ☐Impotence ☐Sores on Genitals ☐Waking at Night to Urinate (how many times) ☐Other (please specify):

______________________________

**26.Musculoskeletal (please check all that apply):** ☐Neck Pain ☐Back Pain ☐Knee Pain ☐Muscle Pain ☐Foot/Ankle Pain ☐Shoulder Pain ☐Hip Pain ☐Hand/Wrist Pain ☐Sciatica ☐Muscle Weakness ☐Other Joint/Bone Problems (please specify): ______________________________

**27.Psychological and Neurological (please check all that apply):** ☐Seizures ☐Dizziness ☐Loss of Balance ☐Areas of Numbness ☐Poor Memory ☐Lack of Coordination ☐Concussion ☐Depression ☐Anxiety ☐Bad Temper ☐Easily Stressed ☐Attempted Suicide ☐Emotional Problems ☐Other (please specify)

______________________________

**28. Autoimmune and inflammatory conditions:** ☐ hashimoto's disease (thyroid) ☐ rheumatism ☐ systemic lupus erthematosus ☐ colitis☐ crohn's ☐ alopecia (baldness) ☐ allergy ☐ food allergy ☐ atopic dermatitis ☐ neurodermatitis ☐ cellulitis ☐sinus allergy ☐ vulvitis ☐other: ______________

**29. Allergies:** ☐ Yes ☐ No (Check Type: ☐Animal products/gelatin ☐ Citrus ☐Honey ☐Pollen ☐Fermented products ☐Shellfish☐ Soy ☐Talc ☐Wheat ☐Grass ☐Other (Please Describe): ______________________

**30.Family Medical History: (check all which apply and specify which blood relative-father, mother, grandparents, brothers, or sisters):** ☐Cancer (List below:type/family member) ☐High Blood Pressure ☐Hepatitis Rheumatic Fever ☐Infectious Disease ☐Diabetes ☐Heart Disease ☐Seizures ☐Emotional Disorder ☐Tuberculosis ☐Other (please specify)______________________________

**31.Sleep:** ☐Can't fall asleep, but once asleep stays asleep ☐Wakes easily☐tossing and turning, excessive dreaming/easily awakened, irritability ☐Grinds teeth in sleep ☐Restless sleep ☐Dream disturbed sleep ☐Sleep Apnea ☐Violent dreams ☐Dreamless sleep ☐After eating Lethargy or sleepiness ☐Fatigue after eating ☐Other sleep issues:

______________________________

| Number of hours per night that you sleep: | | Do you awake very early and are then unable to go back to sleep? | ☐ *Yes* ☐ *No* |
|---|---|---|---|
| Do you have trouble | ☐Yes ☐ No | Do you wake up frequently? | ☐ *Yes* ☐ *No* |

| falling to sleep? | | If so when? | |
|---|---|---|---|

32. **Beverage intake/Smoking/Recreational:** ☐Coffee ☐Black Tea ☐Caffeinated Beverages (☐Recreational Drug: ☐ Yes ☐ No) (☐Tobacco ☐ yes ☐ No ☐ Ever Smoked? ☐Yes☐ No If yes, when Quit: __________________ a. If smoking, how many cigarettes do you smoke daily? _____ b. How many of packs do you smoke daily? ______ ☐Alcohol : ☐ yes ☐ No (Amount per day? ________ # per week? _______ ☐Exercise (please specify type, how often, and length of time):________________________________

33. **Lifestyle: (rest, stress, emotions, tendencies, balance between work and play):** Check all that apply: ☐Anxiety ☐Mania ☐Panic Attacks ☐Mood Swings ☐Depression ☐Seasonal Affective Disorder ☐Other:________________________________

**Hobbies?** ☐Yes☐No ☐If No: Why? ______________ (Type): ____________________

Do you feel you maintain a healthy balance between work and relaxation? ☐Yes☐No ☐If No, Explain:

________________________________________________________________

**Travel:** Places visited within the past year: (any out of country travel)? ____________________

**Working environment:** ☐Good ☐. Bad Explain:________________________________

**Living Conditions:** (Home situation): _☐Good ☐. Bad Explain: ____________________

34. **(Female): Gynecological (please fill in where necessary): If Applicable:**

**Are you Pregnant:** ☐Yes ☐No **Trying to conceive:** ☐Yes ☐No **Problems with conception:** ☐Yes ☐No

Age of 1st Period _____ Age at menopause ____ # of Pregnancies _____ #of Live Births _______

# of Premature Births _____ # of Miscarriages/Abortions ______ # of days between periods _____

# of days of flow ____ Color of blood: (light/dark)/(thick or thin) ☐Clots: ☐ Yes☐ No (Color: _____)

☐Painful Menses ☐Irregular Menses ☐Premenstrual Symptoms ☐Strong Menstrual Odor ☐Vaginal Discharge ☐Vaginal Odor ☐Vaginal Dryness ☐Fibroids ☐Breast Lumps/Swellings ☐Endometriosis ☐Ovarian Cysts ☐Sexually Transmitted Disease ☐Urinary Tract Infection ☐Hot Flashes ☐Decreased Sex Drive ☐Other (please specify):____________________

________________________________________________________________

35. **(Male): Issues: (Reproductive issues, Sexual function) If Applicable: Please Explain:** ____________

________________________________________________________________

36. **Do you have any scars?** ☐Yes☐No (Note location of all operation or injury scars, even minor ones below):

________________________________________________________________

________________________________________________________________

| **Any additional comments/concerns not covered listed in the above intake:** |
|---|
| |
| |
| |
| |
| |
| |
| |
| |
| |

**The information that I have documented on this form is accurate and I will advise the practitioner of any changes in my health or changes in my medications, nutritional supplements and dietary habits.**

**Signature of Patient:** ______________________________ **Date:** ____________________

**Signature of Practitioner:** ____________________________ **Date:** ____________________

Indicate with **one** check any condition that you **sometimes** experience: use **two** checks for those that occur **often**; and *three* checks for symptoms that are a ***major concern***.

**WATER ELEMENT**

Hearing loss ______
Dizziness ______
Lower back pain ______
Neck pain ______
Edema ______
Darkness under eyes ______
Emotional instability ______
Aversion to cold ______
Hair thinning or loss ______
Premature aging ______
Frequent urination ______
Kidney stones ______
Perspire very easily ______
Weak legs or knees ______
Asthmatic cough ______
Rapid weight change ______
Loose teeth, etc. ______
Reduced sexual energy ______
Thyroid problems ______
Diabetes ______
Craves salty foods ______
Lots of nervous Energy ______
Restlessness ______
Tired from 3-7pm ______
Lacking ambition ______
Anxiety ______
Suspiciousness ______
Easily frightened ______
Loves excitement, things that get your adrenaline Pumping: horror movies, driving fast, extreme sports, etc. ______

**EARTH ELEMENT**

Indigestion ______
Flatulence ______
Food Allergy ______
Stomach Ulcer ______
Diarrhea ______
Anemia ______
Bad breath ______
Sores in mouth ______
Heartburn ______
Strong appetite ______
Weak appetite ______
Nausea ______
Abdominal bloating ______
Bruise easily ______
Likes to sing ______
Craving sweets ______
Worrier ______
Overly sympathetic ______
Unsympathetic ______
Poor appetite ______
Excessive appetite ______
Poor relationship with mother ______
Reluctant to leave Home ______
Feeling insecure ______

**WOOD ELEMENT**

Irritability ______
Headaches ______
Migraines ______
Sciatica ______
Tendonitis ______
Bursitis ______
Ringing in the ears ______
Poor eyesight ______
Eye infection ______
Dry eyes ______
Eczema, etc. ______
Shingles ______
Herpes simplex ______
Warts ______
Nervousness ______
Spasms, Convulsions ______
Constipation ______
Hemorrhoids ______
Hepatitis ______
Ulcer ______
Vomiting ______
Gallstones ______
Indecisive ______
Fullness below ribs ______
Shoulder/neck tension ______
Insomnia 11pm-3am ______
Slow to make changes ______
Regretful ______
Immaturity ______
Angers easily ______
Unassertive ______
Avoids conflict ______
Likes sour foods, pickles, vinegar ______
Creatively stifled ______
Despondency ______

**OTHER**

Fatigue ______
Arthralgia ______ (OA or RA)

**METAL ELEMENT**

Bronchitis ______
Asthma ______
Shallow breathing ______
Cough ______
Sinus congestion ______
Nasal infections ______
Spontaneous sweating ______
Very organized ______
Conflict with father ______
Grief/Sadness ______
Disappointment ______
Rich inner life ______
Unsatisfied with work, life, relationships ______
Feeling inadequate ______
Feeling Guilty ______
Lack of self-worth ______
Excessively self-critical ______
Awakens at 3-5am ______

**FIRE ELEMENT**

Skin eruptions ______
Rashes ______
Cysts, tumors ______
Ear infection ______
Sore throat, tonsillitis ______
Lumps, swellings ______
Hot palms & soles ______
Heat aggravates pain ______
Heart palpitations ______
Aversion to heat ______
Bitter taste in mouth ______
Gum problems ______
Nose bleed ______
Facial redness ______
Itching/burning skin ______
Hot hands/feet ______
Thirsty ______
Vivid dreaming ______
Dark urine ______
Restless from 11-1pm ______
Trouble sleeping 7-11pm ______
Night sweats ______
Likes bitter flavors ______
Jolly façade ______
Broken-heartedness ______
Loneliness ______
Trouble giving ______
Trouble receiving ______
Lack of joy in demeanor, work or relationships ______

# 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 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 side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. 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 and benefits 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:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**

PATIENT NAME:

# ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpráctice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

PATIENT SIGNATURE **X** (Date)

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

OFFICE SIGNATURE **X** (Date)

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

# ACUPUNCTURE INTIAL INTAKE

Date:

Name:

Main Concern:

Additional Concerns:

Tongue:

Pulses: Rt Left Diagnosis:

cun

guan

chi

Points:

Rcc:

# ACUPUNCTURE INTIAL INTAKE

Date:

Name:

Main Concern:

Additional Concerns:

Tongue:

Pulses: Rt Left Diagnosis:

cun

guan

chi

Points:

Rec: