Patient Intake Form — Park Poke

Date: _____Name:_____Parent (under 18):_____

Address: _____City:_____State:_____Zip:_____

Date of Birth: _____ Age: _____ Job:_____

Cell #:_____Home#:_____Email:_____

Emergency Name / Phone:_____Doctor:_____

Current Medications: (Include over the counter, supplements, vitamins, herbs)

How did you find us? Referral:_____ Internet:_____Other:_____

Have you had acupuncture before? _____ From whom?_____

Payment due at the time of service. Full fee for cancellations without 24 hrs notice.

Signature: _____ Date: _____

What are your health goals? And why is this important to you?

1.

2.

3.

For what problems are you currently seeking treatment? Rate the severity of each on a scale of 1-10, 1 = not bad at all, 10= the worst imaginable

1.

2.

3.

What impact are your symptoms currently having on your life? What are they preventing you from doing? Why is this important to you?

1.

2.

3.

What methods have you tried in the past to remedy these problems and how did these work for you?

What roadblocks or challenges are stopping you from getting where you want to go? Circle the biggest one.

1.

2.

3.

Name_____Date_____

1. Health History: Have you ever been diagnosed with any of the following?

__ Tension Headaches
__ Migraine Headaches
__ TMJ Disorder
__ Back Pain or Sciatica
__ Chest Pain or Angina Pain
__ Abdominal Pain
__ Pelvic or Genital Pain
__ Rheumatoid Arthritis
__ Osteoarthritis
__ Fibromyalgia
__ Chronic Fatigue Syndrome
__ Bone Fracture/Joint Sprain
__ Muscle Spasm or Tremor
__ Carpal Tunnel Syndrome
__ Tennis Elbow
__ Frozen Shoulder
__ Peripheral Neuropathy
__ Shingles (Herpes Zoster)

__ Coronary Disorder or Heart Attack
__ Lung or Respiratory Disorder
__ Liver Disease or Hepatitis
__ Urinary or Bladder Infection
__ Kidney Disorder or Kidney Stones
__ Gall Bladder Disorder of Gall Stones
__ Spleen or Lymphatic Disorder
__ Gastric or Peptic Ulcer
__ Irritable Bowel Syndrome or Colitis
__ Diabetes
__ Hypoglycemia
__ Thyroid Disorder
__ Dysmenorrhea (Painful Menstruation)
__ Pre-Menstrual Syndrome
__ Prostate or Vaginal Disorder
__ Skin Disorder, Eczema, Psoriasis
__ Raynaud's Disease
__ Deafness or Tinnitus

__ High Blood Pressure
__ Low Blood Pressure
__ Stroke
__ Seizures or Epilepsy
__ Concussion
__ Cancer or Tumors
__ HIV+ or AIDS
__ Multiple Sclerosis
__ Polio or Mono
__ Seasonal Allergies
__ Asthma or Bronchitis
__ Tuberculosis
__ Pneumonia
__ Attention Deficit
__ Obsessive-Compulsive
__ Panic Attacks/Phobias
__ Major Depression
__ _____

2. Accidents: Have you ever been injured in any of the following types of accidents?

__ Automobile Accident
__ Athletic Injury
__ Work Related Accident
__ Surgical Complication
__ Accident at Home
__ Other Accident

3. Current Conditions: In the past year, have you noticeably experienced any of the following?

__ Cold Hands or Feet
__ Swollen Ankles or Feet
__ Stiff, Aching Joints
__Grinding Your Teeth
__Excessive Sweating
__Hyperventilation
__Lethargy, Fatigue
__Large Weight Gain or Loss
__Overeating or Binge Eating
__Under eating or Poor Appetite
__Nausea or Vomiting
__Diarrhea
__Dizziness or Fainting
__Difficulty Sleeping
__ Sinus Congestion
__ Colds, Flu or Chills
__Anxiety
__Depression
__ Constipation
__Blurred Vision
__ Disturbing Dreams

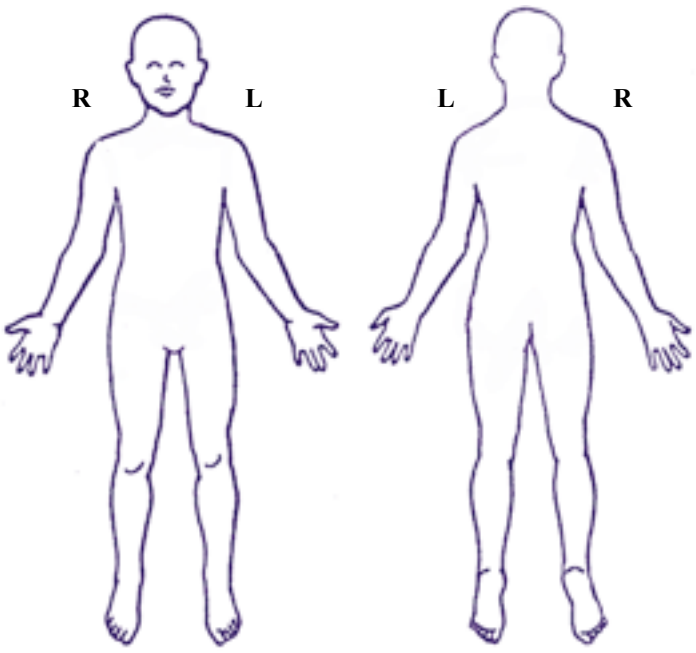
4. Do you have Stress around the following?

__Job
__Food/Eating
__Relationships
__Health
__Finances
__ _____

5. Substances or Medications: In the past 6 months, did you regularly take any of these?

__ Cigarettes, Cigars, Vaping
__ Aspirin or Tylenol
__ Sleeping Pills
__ Several Cups of Coffee/Day
__ Prescribed Pain Reliever Medication
__ Alcoholic Beverages
__ Recreational Drugs/Marijuana
__ A lot of Soda
__ Anti-Anxiety Pills
__ Anti-Depressants

6. Mark the areas where you are experiencing pain:



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)