

# Patient Intake Form — Edgewater Acupuncture

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.** \$35 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?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Tension Headaches          | <input type="checkbox"/> Coronary Disorder or Heart Attack    | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Migraine Headaches         | <input type="checkbox"/> Lung or Respiratory Disorder         | <input type="checkbox"/> Low Blood Pressure    |
| <input type="checkbox"/> TMJ Disorder               | <input type="checkbox"/> Liver Disease or Hepatitis           | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Back Pain or Sciatica      | <input type="checkbox"/> Urinary or Bladder Infection         | <input type="checkbox"/> Seizures or Epilepsy  |
| <input type="checkbox"/> Chest Pain or Angina Pain  | <input type="checkbox"/> Kidney Disorder or Kidney Stones     | <input type="checkbox"/> Concussion            |
| <input type="checkbox"/> Abdominal Pain             | <input type="checkbox"/> Gall Bladder Disorder or Gall Stones | <input type="checkbox"/> Cancer or Tumors      |
| <input type="checkbox"/> Pelvic or Genital Pain     | <input type="checkbox"/> Spleen or Lymphatic Disorder         | <input type="checkbox"/> HIV+ or AIDS          |
| <input type="checkbox"/> Rheumatoid Arthritis       | <input type="checkbox"/> Gastric or Peptic Ulcer              | <input type="checkbox"/> Multiple Sclerosis    |
| <input type="checkbox"/> Osteoarthritis             | <input type="checkbox"/> Irritable Bowel Syndrome or Colitis  | <input type="checkbox"/> Polio or Mono         |
| <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Seasonal Allergies    |
| <input type="checkbox"/> Chronic Fatigue Syndrome   | <input type="checkbox"/> Hypoglycemia                         | <input type="checkbox"/> Asthma or Bronchitis  |
| <input type="checkbox"/> Bone Fracture/Joint Sprain | <input type="checkbox"/> Thyroid Disorder                     | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Muscle Spasm or Tremor     | <input type="checkbox"/> Dysmenorrhea (Painful Menstruation)  | <input type="checkbox"/> Pneumonia             |
| <input type="checkbox"/> Carpal Tunnel Syndrome     | <input type="checkbox"/> Pre-Menstrual Syndrome               | <input type="checkbox"/> Attention Deficit     |
| <input type="checkbox"/> Tennis Elbow               | <input type="checkbox"/> Prostate or Vaginal Disorder         | <input type="checkbox"/> Obsessive-Compulsive  |
| <input type="checkbox"/> Frozen Shoulder            | <input type="checkbox"/> Skin Disorder, Eczema, Psoriasis     | <input type="checkbox"/> Panic Attacks/Phobias |
| <input type="checkbox"/> Peripheral Neuropathy      | <input type="checkbox"/> Raynaud's Disease                    | <input type="checkbox"/> Major Depression      |
| <input type="checkbox"/> Shingles (Herpes Zoster)   | <input type="checkbox"/> Deafness or Tinnitus                 | _____  |

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Automobile Accident | <input type="checkbox"/> Work Related Accident | <input type="checkbox"/> Accident at Home |
| <input type="checkbox"/> Athletic Injury     | <input type="checkbox"/> Surgical Complication | <input type="checkbox"/> Other Accident   |

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

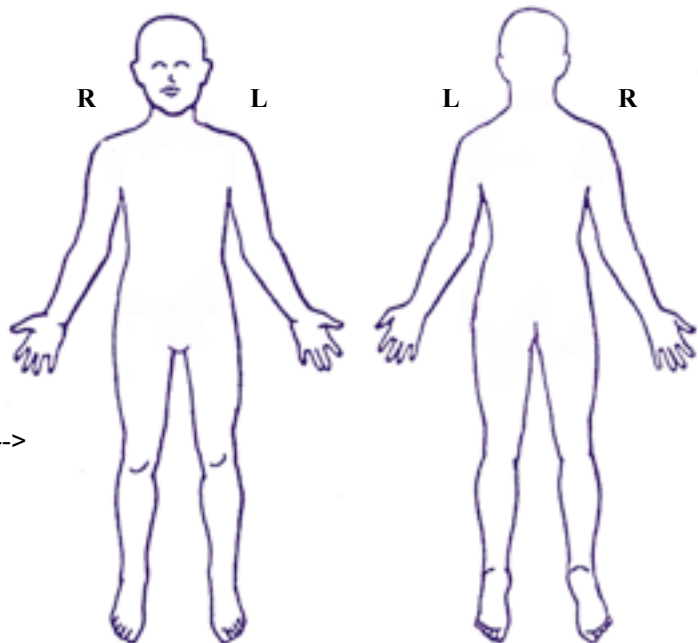
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cold Hands or Feet     | <input type="checkbox"/> Large Weight Gain or Loss     | <input type="checkbox"/> Sinus Congestion     |
| <input type="checkbox"/> Swollen Ankles or Feet | <input type="checkbox"/> Overeating or Binge Eating    | <input type="checkbox"/> Colds, Flu or Chills |
| <input type="checkbox"/> Stiff, Aching Joints   | <input type="checkbox"/> Under eating or Poor Appetite | <input type="checkbox"/> Anxiety              |
| <input type="checkbox"/> Grinding Your Teeth    | <input type="checkbox"/> Nausea or Vomiting            | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Excessive Sweating     | <input type="checkbox"/> Diarrhea                      | <input type="checkbox"/> Constipation         |
| <input type="checkbox"/> Hyperventilation       | <input type="checkbox"/> Dizziness or Fainting         | <input type="checkbox"/> Blurred Vision       |
| <input type="checkbox"/> Lethargy, Fatigue      | <input type="checkbox"/> Difficulty Sleeping           | <input type="checkbox"/> Disturbing Dreams    |

**4. Do you have Stress around the following?**

- |                                      |  |                                   |
|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Job         | <input type="checkbox"/> Relationships | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Food/Eating | <input type="checkbox"/> Health        | _____                             |

**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: *Edgewater Acupuncture, LLC*

PATIENT SIGNATURE

**X**

(Date)

(Or Patient Representative)

(Indicate relationship if signing for patient)