

Appointment Date: _____

I 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 # _____ May we contact them? Y/N

Have you had Acupuncture or Oriental medicine before? Y/N

Are you presently under a doctor's care? Y/N Who and for what? _____

Are there any other therapies which you are involved? Y/N Who and for what? _____

II Insurance Information

Insurance Company _____ Contact # _____

Group/Plan # _____ Co-pay \$ _____ Visit # _____ Referral Y/N Covered % _____ Ded.(?) _____

Date called _____ Contact Name _____

III 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?

<input type="checkbox"/> Work	<input type="checkbox"/> Standing	<input type="checkbox"/> Sexually	<input type="checkbox"/> Other
<input type="checkbox"/> Sleep	<input type="checkbox"/> Emotional	<input type="checkbox"/> Recreation	_____
<input type="checkbox"/> Walking	<input type="checkbox"/> Relationships	<input type="checkbox"/> Bending	_____
<input type="checkbox"/> Sitting	<input type="checkbox"/> Social Life	<input type="checkbox"/> Stretching	_____

What have you done about this? _____

Are you interested in:

<input type="checkbox"/> Pain Relief	<input type="checkbox"/> Performance Care	<input type="checkbox"/> Maintenance Care	<input type="checkbox"/> Other
<input type="checkbox"/> Preventative Care	<input type="checkbox"/> Holistic Health	<input type="checkbox"/> Stress Relief	_____
<input type="checkbox"/> Oriental Nutrition	<input type="checkbox"/> Meridian Yoga	<input type="checkbox"/> Herbal Therapy	_____

What are your health goals? _____

List any past or future surgeries. _____

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

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

IV Signs/Symptoms

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

V Female Concerns

Date of last menstruation _____ Is your cycle regular? Y/N _____ Is your cycle painful? Y/N _____ Have you ever been pregnant? Y/N _____

Birth control? Y/N _____ How long? _____ PMS Clotting Vaginal sores Vaginal pain Discharge

VI Medical History

Do you have any allergies? Y/N _____ If so, to what? _____

Do you take medication? Y/N _____ If so what types and how often _____

Do you take supplements? Y/N _____ If so what types and how often _____

- Please indicate if you or any family members have or had any of the following conditions:
- Pneumonia
 - Tuberculosis
 - Hepatitis
 - Diabetes
 - Epilepsy
 - Kidney Stone
 - Drug reaction
 - Heart attack
 - Blood transfusion
 - Anemia
 - Arthritis
 - Obesity
 - Metal breakdown
 - Jaundice
 - Parasites
 - Measles
 - Mumps
 - Syphilis
 - Gonorrhea/Herpes
 - HIV/Aids
 - High/low blood pressure
 - Heart disease
 - Gout
 - Cancer
 - Mental illness
 - Hypo/hyper thyroid
 - Premature graying
 - Seizures
 - Multiple Sclerosis

Do you sleep well? Y/N

Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____ Do you have a low point during the day? Y/N When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

VII Web of Wellness

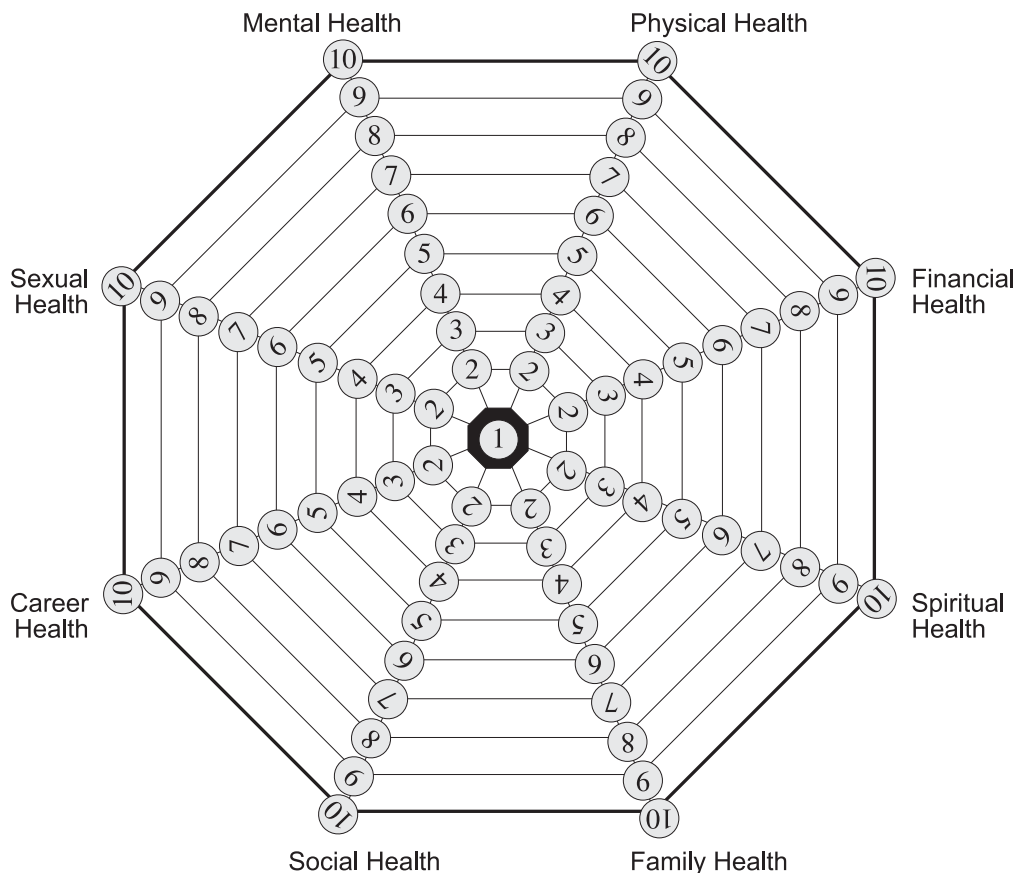
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

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



VIII 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
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Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep
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Work - Can do:

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

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

No problem on long trips	Moderate pain on trips	Severe pain
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Recreation - Can do:

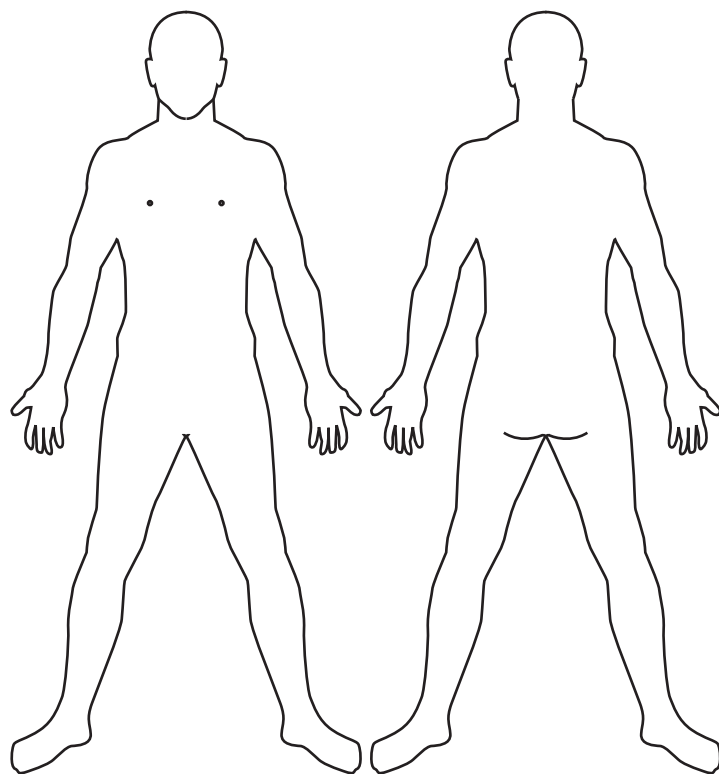
All activities	Some activities	No activities
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Walking

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

No pain sitting	Some pain while sitting	Cannot sit
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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

When a client seeks acupuncture health care and I accept a patient for such care, it is essential for both to be working toward the same objectives.

Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood, and other body fluids. When this is done correctly, the body will have the capacity to obtain and maintain health and well-being.

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Acupoint stimulation: The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

Health: A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

Qi imbalance: When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential

I do not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination I encounter non-acupuncture or unusual findings, I will advise you. If you desire advice, diagnosis or treatments of those findings, I will recommend that you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help to facilitate healing and a potentially lead to a full expression of your body's innate wisdom.

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 on this basis.

(Signature) _____ (date) _____