



Acupuncture Patient In-take Form

Name _____ Date of Birth _____

Phone Number _____ Alternate Phone _____

Address _____

Email Address _____

Referred By _____

Emergency Contact

(Name) _____

(Phone number) _____ Relationship _____

Family Physician

(Name) _____ (Phone number) _____

Insurance Carrier

Reason for Today's Visit/Health Goals You Would Like to Achieve

Medical History (ex: surgery, trauma, major health incidents)

Acupuncture Patient In-Take Form

Please list any medications you are taking.

Medication

Reason

Dosage and how long you have been taking

Please fill out completely. **One** check mark for symptoms you have experienced. **Two** check marks for symptoms that are particularly distressing to you.

Head & Face

- Headaches
- Dizziness
- Memory Loss
- Light Headedness
- Red/Itchy/Teary Eye
- Sinus Trouble
- Jaw Pain
- Other_____

Heart & Chest

- High Blood Pressure
- Low Blood Pressure
- Chest Pain/Tightness
- Heart Palpitations
- Pacemaker
- Other_____

Neurological

- Anxiety
- Tremors
- Numbness/Tingling
- Loss of Coordination
- Nerve Pain
- Other_____

Urination

- Frequent
- Difficult
- Painful
- Burning
- Other_____

Skin

- Acne
- Dryness/Itchy
- Excessive Sweat
- Night Sweats
- Bruising/Bleeding
- Cold Hands & Feet
- Other_____

Sleep

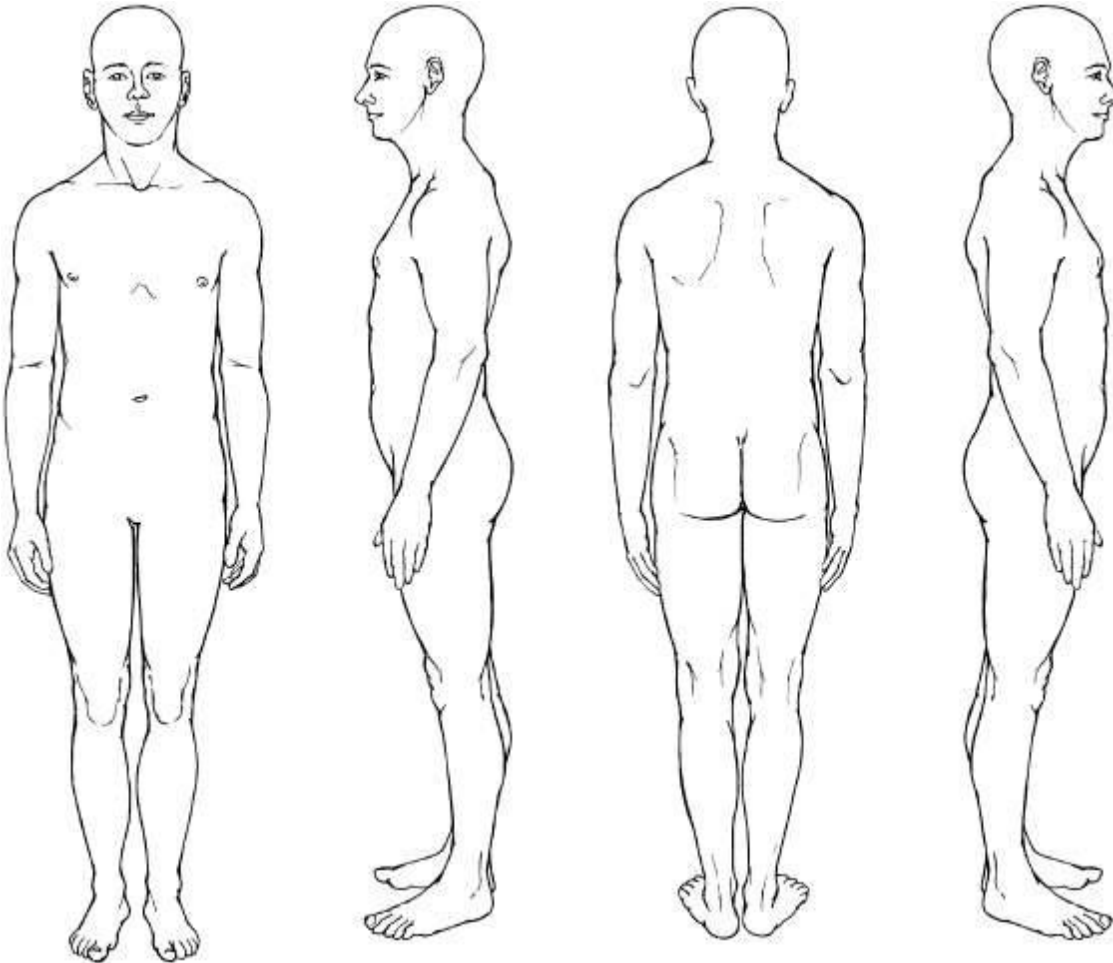
- Insomnia
- Difficult to fall asleep
- Waking easily
- Drowsiness
- Excessive Dreaming
- Nightmares
- Other_____

Gastrointestinal

- Abdominal Pain
- Heartburn/Reflux
- Gas/Bloating
- Constipation
- Diarrhea/Loose Stool
- Excessive or Absent Appetite
- Excessive or Absent Thirst
- Vomit/Nausea
- Other_____

This page will help us to understand your pain. If you are not experiencing any pain, it is not necessary to fill out.

Use circles or X's to indicate where you are experiencing symptoms.



Identify the overall intensity of your pain.
Circle the number that best correlates with your pain.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Try to explain your pain using descriptive words. How does it feel?
(Examples: Dull-Burning-Sharp-Stabbing-Achy-Catching-Numbness-Tingling-Stiffness-Tightness)

Consent to Treatment Form

By signing below, I voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the Acupuncture & Bodywork Clinic. I understand that acupuncturists practicing in the state of Minnesota are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that counteractive side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a slight risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Acupuncture & Bodywork Clinic as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that counteractive side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____

Date: _____