CONFIDENTIAL ACUPUNCTURE INTAKE

Legal Name (last, first, middle initial): ______________________________ **Date:** ____/____/____

Birth Date: ____/____/____ **Age:** ______ **Patient sex:** □Male □Female **Social Security No:** ______________

Street Address: ______________________________ **City:** ______________ **State:** ______ **Zip:** ______

Home Phone: (___) __________ **Mobile Phone:** (___) __________ **Email Address:** ______________

Employer: ______________________________ **Occupation:** ______________

Emergency Contact Name: ______________________________ **Emergency Contact Phone:** (___) __________

Please check appropriate box: □Single □Married □Partnered □Divorced □Widowed □Separated **Referred By:** __________

Insurance Co. (primary): ______________________ **Insurance Co. (secondary):** ______________________

Name of Insured: ______________________________ **Relationship to Patient:** ______________

Insured's Social Security No: ______________________ **Employer:** ______________________

Insured's Birth Date: ____/____/____ **Insured's Sex:** □Male □Female

Physician: ______________________________ **Permission to consult with your physician?** Yes No

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CHIEF COMPLAINT: ______________________________

When / how did this start: ______________________________

Symptoms: ______________________________

List any other Doctors or Therapists you have seen for this condition:

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Recommendations: ______________________________

Treatment(s) received: ______________________________

Are symptoms: Better Worse Unchanged (please circle one)

What makes symptoms worse? ______________________________

What makes symptoms better? ______________________________

Symptoms experienced what percentage of time during a day? 0-25% 26-50% 51-75% 76-100% Other: __________

List previous accidents or injuries (auto, work, falls, etc.) including dates: ______________________________

____

List any previous surgeries, including dates: ______________________________

____

List all medications (prescription / non-prescription meds, supplements, herbs), dosage, and when you started/stopped each med:

____

____

____

Habits	Never	Rarely	Occasionally
Coffee:	□	□	□ Weekly/Daily Amount: ______________
Black tea:	□	□	□ Weekly/Daily Amount: ______________
Soda:	□	□	□ Weekly/Daily Amount: ______________
Tobacco:	□	□	□ Weekly/Daily Amount: ______________
Alcohol:	□	□	□ Weekly/Daily Amount: ______________
Laxatives:	□	□	□ Weekly/Daily Amount: ______________
Aspirin/NSAIDS:	□	□	□ Weekly/Daily Amount: ______________

Exercise: (please describe type/amount) ______________________________

Stress management tools: ______________________________

Current Health Condition (please circle symptoms which have occurred in the past year)

Energy, Immunity, and Metabolism

Fatigue	Catch colds easily	Allergies	Feeling hot/flushed
Energy drops	Slow wound healing	Sweat easily	Fever/chills
General weakness	Chronic infections	Day/night sweats	Recent weight gain/loss

Head, Eyes, Ears, Nose, and Throat

Headaches/migraines	Photosensitivity	Sinus problems/snoring	Sore throat/swollen glands
Dizziness/vertigo	Eye strain/pain/floaters	Nasal congestion	Hoarseness/loss of voice
Vision changes/blurriness	Ear ringing/earaches	Nosebleeds	Teeth grinding

Respiratory and Cardiovascular

Asthma/wheezing	Cough	Palpitations	Varicose/spider veins
Difficulty breathing	Chest tightness/pain	High/low blood pressure	Fainting
Phlegm	Cold hands or feet	High cholesterol	Fluid retention/edema
Pneumonia	Bronchitis	Blood clots	History heart attack/stroke

Gastrointestinal

Low/excessive appetite	Heartburn/acid reflux/ulcers	Dental/gum problems	Diarrhea/loose stools
Difficulty chewing/swallowing	Strong thirst	Abdominal pain/cramps	Constipation
Bad breath	Belching/hiccups	Intestinal gas/bloating	Hemorrhoids/rectal pain
Nausea/vomiting	Gallbladder stones	Food/drug allergies? ______________________	

Bowel Movements

Frequency: _______ Blood/mucous in stool Incomplete feeling/pain/urgency Undigested food

Consistency: well-formed dry hard pellets loose soft sticky alternating

Color: brown white/chalky green yellow orange

Genitourinary

Pain/urgency/burning	Frequent urination	Kidney stones	Change in sex drive
Nighttime urination	Profuse/decreased urination	Urinary retention	Incontinence/dribbling
Blood in urine	Urinary tract infections	Bed wetting	Herpes/STDs/genital sores

Skin, Hair, and Nails

Dry skin/scalp/dandruff	Itching/eczema/psoriasis	Rashes/hives	Acne/sores
Easy bruising	Weak/brittle/ridged nails	Scars/moles	Hair loss/thinning

Neurological and Musculoskeletal

Muscle weakness	Lack of coordination/balance	Muscle spasms/tics/tremors	Numb/tingling/paralysis
Seizures/epilepsy	Poor concentration/memory	Slurred speech	Concussion/TBI/Stroke

Pain: Yes No Describe location of pain: ______________________

Sleep

Difficulty falling/staying asleep	Vivid dreams	Nightmares/night terrors	Sleep talking/walking
Tired upon waking	Restlessness	Avg hours of sleep: _______	Typical bedtime: _______

Emotions

Mood swings	Nervous/anxiety/panic attacks	Frequent worrying/fear	Depression
Seasonal affective disorder	Sadness/tearfulness	Irritability/anger/frustration	Obsessive/compulsive
Mania/elevated mood	Describe your level of happiness: ______________________		

Men Only

Prostate disease	Testicular pain/swelling	Low/excessive sex drive	Premature ejaculation
Hernia	Impotence	Difficulty reaching orgasm	Nocturnal emissions
Poor sperm motility	Irregular morphology	Low sperm count	# of children: _______

Women Only

Hot flashes/flushing	Facial hair growth	Fibroids/cysts/PCOS	Endometriosis
Abnormal vaginal discharge/odor	Nipple discharge	Breast tenderness/lumps	Vaginal dryness
Infertility	Spotting between periods	Difficulty reaching orgasm	Pain during intercourse

First day of last menstrual period: __________ Duration of menstrual cycle (ex: 28 days): __________

Duration of period (ex: 5 days): __________ Date of last PAP/pelvic exam: __________ Age of 1st period: __________

Are cycles regular? Yes No Any abnormal exam results? __________ PMS symptoms: __________

Birth control? Yes No Type: __________ **Is there any possibility that you are currently pregnant? Yes No**

Number of pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Have you experienced menopause? Yes No If so, when? __________

Please describe menopausal symptoms: ______________________

By signing below, I indicate the information above is complete and accurate to the best of my knowledge at this time.

______________________ ______________

Patient Signature (if minor, parent or guardian must sign) Date

Consent to Acupuncture Treatment

By signing below, I do herby voluntarily consent to be treated with acupuncture and/or substances from the Chinese Materia Medica by a licensed acupuncturist at Mount Rainier Clinic. I understand that acupuncturists practicing in the state of Washington 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 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 disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse 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.

Chinese Herbs: I understand that substances from the Chinese Materia Medica may be recommended to me to treat bodily dysfunction or disease, 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 effects 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 Peninsula Naturopathic Clinic as soon as possible.*

Acupressure/Tuina Massage: I understand that I may also be given acupressure/Tuina massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse 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.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to, electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

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 of any of the abovementioned treatments at any time. I give my permission and consent to treatment.

Signature: ____ **Date:** ________________

(In case of minor, parent or guardian must sign)

Printed Name: ____