

Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Sex: F M SSN: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____ Physician's phone: _____

Referred by: _____ How did you hear about us? _____

Consent for Acupuncture

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

Patient's signature (Parent or Guardian if under 18)

Date

Reason you are seeking acupuncture: _____

How long ago did this problem begin? _____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried? _____

Does anything improve your problem? _____

MEDICAL HISTORY (Please list illnesses & surgeries you have or have had and year diagnosed)

Illnesses: _____

Surgeries: _____

Significant Trauma (auto accident, falls etc): _____

Have you ever had any **Infectious Diseases (HIV, TB etc)**? Yes No If so, please describe: _____

Medicines (prescription and OTC, vitamins, herbs etc.)

For what condition

Allergies: _____

FAMILY MEDICAL HISTORY (please check if any of the following applies to any family members)

- AIDS
- Alcoholism
- Allergies
- Asthma
- Cancer
- Diabetes
- Heart disease
- Hypertension
- Seizures
- Strokes
- Pulmonary disease
- Other

If mother, father or siblings are deceased, what was the cause?

CURRENT SYMPTOMS (please check if any of the following applies)

WOOD

- Irritability/Stressed
- Depression
- Headaches/migraines
- Visual problems
- Red eyes
- Dry/itching eyes
- Spots in front of eyes
- Blurred vision
- Feeling of lump in throat
- Clenching of teeth at night
- Muscle cramping
- Muscle twitching
- Joints feel tight/stiff
- Soft/brittle nails
- Craving or avoiding sour foods

WATER

- Urinary problems
- Frequent urination
- Incontinence
- Weakness/pain in lower back
- Aching bones
- Feel cold easily (hands/feet)
- Low sexual energy
- Excess sexual desire
- Poor memory
- Loss of hair
- Hearing problems
- Ringing in ears
- Craving or avoiding salty foods

FIRE

- Heart palpitations
- Chest pain
- Dizziness
- Insomnia
- Easily startled
- Restlessness/agitation
- Anxiety
- Breathlessness
- Vivid dreams
- Dreams are bothersome
- Lack of joy in life
- Laughing for no reason
- Craving or avoiding bitter foods

METAL

- Dry cough
- Cough with sputum
- Nasal discharge
- Poor sense of smell
- Nose bleeds
- Itchy, red or painful throat
- Dry mouth
- Skin rashes
- Itchy skin
- Grief, sadness
- Shortness of breath
- Allergies
- Low resistance to colds or flu
- Low physical stamina
- Mild fever comes and goes
- Craving or avoiding spicy foods

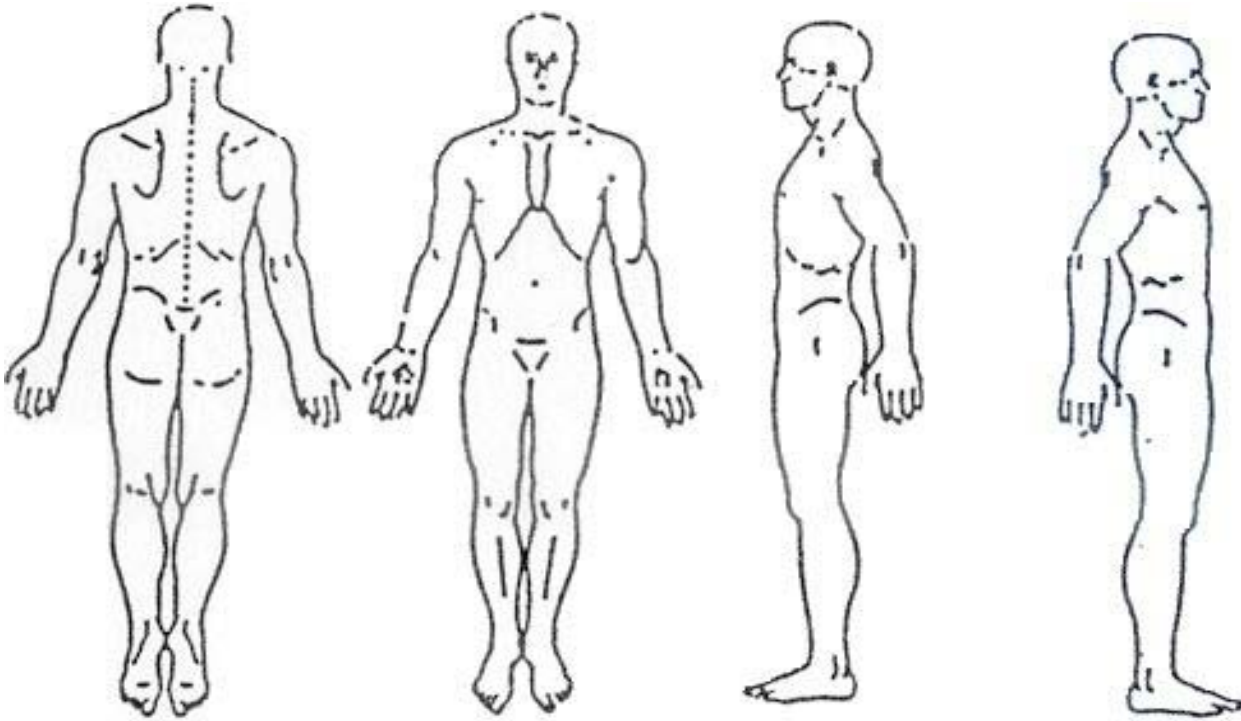
EARTH

- Heaviness anywhere in body
- Fatigue
- Hard to get up in the morning
- Edema (swelling)
- Muscles feel tired often
- Easy bruising and bleeding
- Bad breath
- Low appetite
- Snacking often
- Hypoglycemia/low blood sugar
- Difficulty digesting oily foods
- Nausea
- Vomiting
- Gas/belching
- Bloating
- Hemorrhoids
- Constipation
- Diarrhea
- Abdominal pain
- Indigestion/heartburn
- Over-thinking
- Obsessive tendencies
- Craving or avoiding sweets

OTHER

- _____
- _____
- _____
- _____

Please circle areas of pain or injury



FEMALES

Age at First Menses: _____ Age stopped: _____ Period between Menses: _____ Duration of Menses: _____

Number of Pregnancies: _____ Number of Births: _____ Miscarriages: _____ Abortions: _____

Last period: _____ Last PAP smear: _____ Pregnant: Y N Form of birth control: _____

- Menstrual pain Low backache Irregular menses Painful breast Clots Fertility problems
- Mood changes Hot flashes Vaginal dryness Vaginal discharge Heavy bleeding

MALES

- Erectile dysfunction Premature ejaculation Nocturnal emission Pain/itching of genitalia
- Lumps in testicles Increased libido Decreased libido Other: _____

PERSONAL HABITS

- Coffee # per day _____ Alcohol # drinks per week _____
- Tobacco # per day _____ Former tobacco use # years quit _____
- Recreational drugs # per day _____ Former alcohol use # years quit _____

Do you have a regular exercise program? _____ If so, please describe: _____

DIET (Please describe your typical daily diet)

Breakfast: _____ Morning Snack: _____

Lunch: _____ Afternoon Snack: _____

Dinner: _____ Dinner Snack: _____