NEW PATIENT ACUPUNCTURE INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone #: _____ Email: _____

Emergency Contact: _____ Phone #:_____ Relation: _____

Have you ever received Acupuncture before? Yes / No

What health concern(s) bring you in today? _____

_____

Have you been examined by a medical doctor for any of these health concerns? Yes / No

If yes, what was your medical diagnosis: _____

List any medications/supplements you are currently taking: _____

_____

List any known allergies: _____

List any significant traumas (accidents, falls, injuries): _____

_____

List any significant surgeries you have had:_____

_____

Do you have any type of bleeding disorder or a pacemaker? Yes / No

Do you have any pain? If yes, mark areas that apply:

XXXX Sharp/Stabbing

/ / / / Achy/Tightness

0000 Numbness

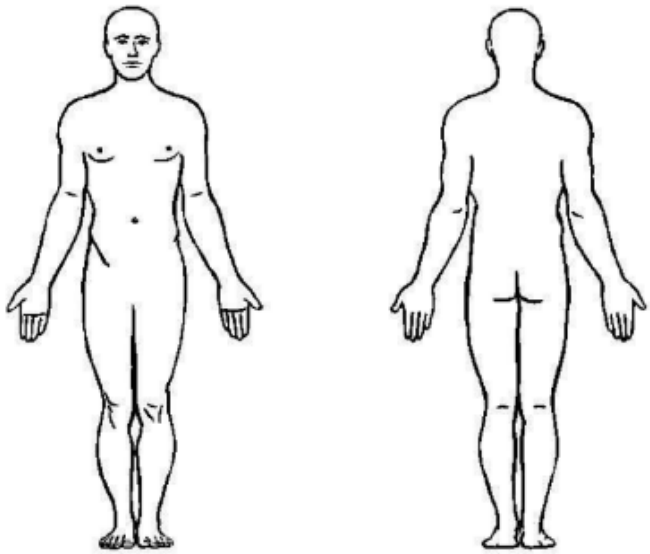
. . . . Pins/Needles

**** Burning

What is your pain level? 1 2 3 4 5

How long have you had this pain? _____

Did it begin suddenly or gradually? Sudden / Gradual



GENERAL HEALTH (Check all that apply):

- ☐ Chills/fever
- ☐ Feel too hot/cold
- ☐ Avoid heat/cold
- ☐ Cold hands/feet
- ☐ Sweaty palms/feet
- ☐ Hot flashes/Night sweats
- ☐ Spontaneous sweating
- ☐ Lack of sweating
- ☐ Excessive/lack of thirst
- ☐ Fatigue
- ☐ None of the above

HEAD (check all that apply):

- ☐ Concussion/Head Trauma
- ☐ Headaches/Migraines
- ☐ Jaw pain/TMJ
- ☐ None of the above

EYES & EARS (check all that apply):

- ☐ Impaired Hearing/hearing loss
- ☐ Ringing in ears/Tinnitus
- ☐ Dizziness
- ☐ Spots in vision/floaters
- ☐ Poor night vision
- ☐ Double/blurred vision
- ☐ Eye pain/strain
- ☐ Dry/itchy/burning eyes
- ☐ Red/inflamed eyes
- ☐ None of the Above

NOSE, THROAT, MOUTH (check all that apply):

- ☐ Recurrent Sinus Infections
- ☐ Runny nose
- ☐ Sneezing
- ☐ Mouth ulcers/bleeding gums
- ☐ Bad breath
- ☐ Dry mouth
- ☐ Recurrent sore throat/hoarseness
- ☐ Difficulty swallowing
- ☐ None of the Above

SKIN and NAILS (check all that apply):

- ☐ Rashes/Hives/Itching
- ☐ Color change of skin
- ☐ Bruise easily
- ☐ Slow wound healing
- ☐ Acne
- ☐ Hair loss
- ☐ Weak/brittle nails
- ☐ None of the Above

CARDIOVASCULAR (check all that apply):

- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Chest Tightness/Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Fainting Spells
- ☐ Swelling of ankles
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Bleeding disorders
- ☐ Poor Circulation
- ☐ None of the Above

DIGESTIVE (check all that apply):

- ☐ Nausea/Vomiting
- ☐ Low appetite
- ☐ Excessive hunger
- ☐ Fatigue after meals
- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Stomach ulcers
- ☐ Acid reflux/heartburn
- ☐ Diarrhea/Loose Stool
- ☐ Constipation
- ☐ Abdominal pain
- ☐ None of the Above

RESPIRATORY SYSTEM (check all that apply):

- ☐ COVID-19 recovery
- ☐ Coughing
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Phlegm
- ☐ Frequent colds/flu
- ☐ None of the Above

URINARY TRACT (check all that apply):

- ☐ Frequent urination
- ☐ Dribbling/Poor bladder control
- ☐ Pale urine
- ☐ Dark urine
- ☐ Cloudy urine
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Burning/painful urination
- ☐ Frequent UTI
- ☐ Kidney/bladder stones
- ☐ None of the Above

PSYCHO-EMOTIONAL (check all that apply):

- ☐ Difficulty falling/staying asleep
- ☐ Vivid/disturbing dreams
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Irritability
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Restless/frequent worry
- ☐ Sad often
- ☐ Fearful often
- ☐ Panic Attacks
- ☐ PTSD
- ☐ Suicidal thoughts
- ☐ Cry uncontrollably
- ☐ None of the Above

Please check any CURRENT or PAST conditions you have experienced:

- ☐ Addiction/Alcoholism
- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Bladder Disease
- ☐ Bleeding disorder
- ☐ Breast lumps
- ☐ Cancer
- ☐ Candida
- ☐ Chronic bronchitis
- ☐ Colitis/IBS
- ☐ Crohn's
- ☐ COPD
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hernia
- ☐ Hepatitis
- ☐ Herpes
- ☐ Hypertension
- ☐ Hypotension
- ☐ HIV positive
- ☐ Mono
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Polio/meningitis
- ☐ Rheumatism/arthritis
- ☐ Shingles
- ☐ Stroke
- ☐ Ulcers
- ☐ Vein conditions
- ☐ Venereal disease
- ☐ None of the Above

MEN'S HEALTH HISTORY

- ☐ Increase/decrease libido
- ☐ Groin/testicular pain
- ☐ Poor erectile function/impotence
- ☐ Premature/lack ejaculation
- ☐ Prostate problems
- ☐ Discharge from penis
- ☐ Other: _____
- ☐ Have you had a vasectomy? Y / N
- ☐ If so, when?_____

WOMEN'S HEALTH HISTORY

Please fill out to the best of your knowledge, even if you are no longer menstruating.

MENSTRUATION

Age when menses began: _____

Menstruation lasts _____days

I have a:

Regular cycle of _____days

Irregular cycle of _____to _____days

During your period, do you experience any:

- ☐ Dysmenorrhea (Cramps)
- ☐ Fatigue
- ☐ Breast tenderness
- ☐ Other: _____

During your period, the flow is:

Light/spotting on days _____

Medium on days _____

Heavy on days _____

What color is the blood?

Light Red on days _____

Bright Red on days _____

Dark Red on days _____

Brown on days _____

REPRODUCTIVE HISTORY

Are you currently using birth control? Y / N

Have you recently stopped or started birth control? Y / N

If so, when? _____

Are you trying to conceive? Y / N

Have you given birth in the last year? Y / N

Are you currently lactating? Y / N

Have you had any:

- ☐ High-risk pregnancies
- ☐ Difficult labor/deliveries
- ☐ Postpartum depression/concerns

MENOPAUSE

Are you perimenopausal? Y / N

Do you currently experience any:

- ☐ Night sweats/Cold flashes
- ☐ Hot flashes (daytime)
- ☐ Sleep Disturbance
- ☐ Spotting
- ☐ Other: _____

Are you postmenopausal? Y / N

When was your last period? _____

Have you had a hysterectomy? Y / N

If so, when? _____

Any pseudo period symptoms? Y/ N

ACUPUNCTURE/CUPPING INFORMED CONSENT TO TREAT

Introductions - I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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.

Method of Treatment - 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.

Risks - I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

Medical Changes - I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

Alternative Treatments - I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

Disclaimer - Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). Informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information which is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

Consent For Acupuncture Treatment

1. I hereby authorize _____SARAH JOHNSON_____ to perform acupuncture and additional accessory techniques. I have received the ACUPUNCTURE INFORMED CONSENT TO TREAT.
2. I recognize that during the course of the acupuncture treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above acupuncturist to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. It has been explained to me in a way that I understand:
    A. The above treatment or exposure to be undertaken
    B. There may be alternative procedures or methods of treatment
    C. There are risks to the procedure or treatment proposed

I Consent To The Treatment Or Procedure And The Above Listed Items (1-4). I Am Satisfied With The Explanation.

Patient Name *(Print)*

Patient Signature (*or Person Authorized to Sign for Patient***)**

Date

Acknowledgement of Notice of Privacy Practices (HIPAA) and Patients' Rights

_____ I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures of Sarah Johnson Acupuncture LLC before I sign this consent form regarding the use and disclosure of my Protected Health Information and I have the right to revoke this consent, in writing, at any time, exempting the acupuncturists and practice to the extent that they have already relied upon this consent.

I acknowledge I have been given the opportunity to read a copy of the Notice of Privacy Practices (HIPAA) and Patients' Rights and fully understand both forms.

Patient Name *(Print)*

Patient Signature (*or Person Authorized to Sign for Patient***)**

Date