Acaciawood
ACUPUNCTURE

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex ☐ F ☐ M	
Date of birth	Age	SSN	
Cell phone#	Home phone#	Allow text contact by us ☐ Yes ☐ No	
Email Address		Allow email contact by us ☐ Yes ☐ No	
Family physican		Occupation	
Address: Street	City	State	Zip
Emergency contact name & phone#		Relationship Status	
How did you find out about our clinic? ☐ *Friends/Relatives (name)*_______________ ☐ *Walk by* ☐ *Health fair/ Public event*________________	☐ *Referred by VA* ☐ *Online Search*__________________ ☐ *Referred by* ___________________ ☐ *Other (please specify)* ____________________		

Main problem(s): ____

What diagnosis, if any, have you received for this problem? ____

When did this problem begin? _____________What are the causes of this problem? ______________________

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? ___________________

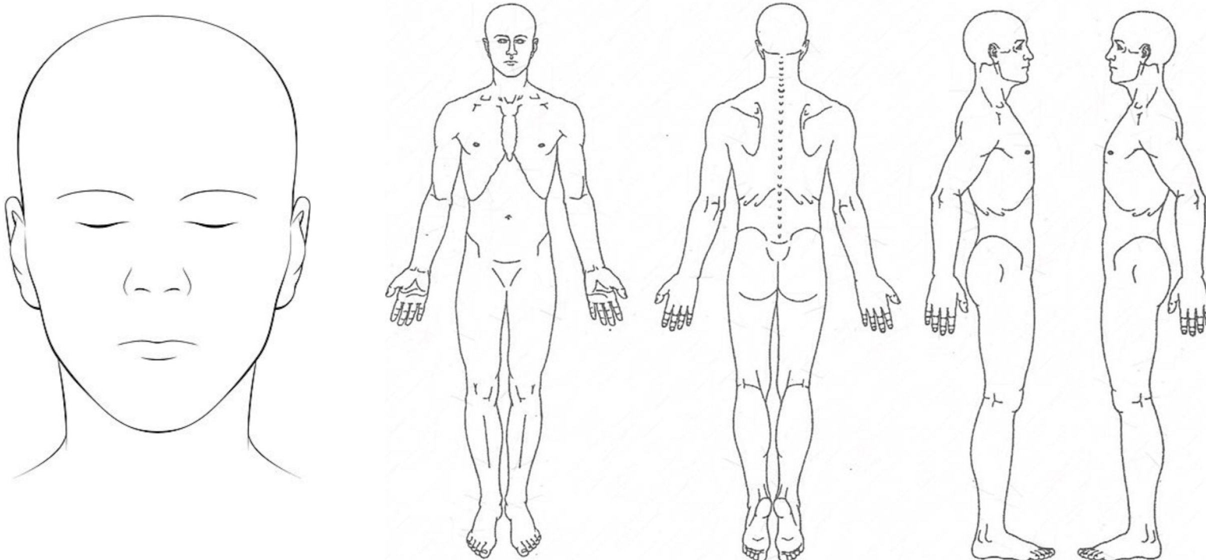
What kind of treatment have you tried? ____

What makes this problem worse? ___________________What makes this problem better? _________________

Is there anybody in your family with the same/similar problems? _______________________________________

Did you had acupuncture before? _______________________________

Indicate painful or distressed areas:



▷ Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: ________________________________ Hospitalization:____________________________

Significant trauma: (auto accidents, sports injuries, etc) ____

Allergies: (drugs, chemicals, foods, environmental)____

Diagnosis	Self	Fmaily	Diagnosis	Self	Fmaily	Diagnosis	Self	Fmaily
Cancer *(what type)*			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthristis			Depression or anxiety			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

____

____

▷ Life Style

Occupation: Do you usually work ☐ indoors ☐ outdoors?

Personal

Height _____________ Stress level _________ (0 to 10)

Weight now _________ Energy level _________ (0 to 10)

Habits

Do you smoke ? ☐ Yes ☐ No What? _______________ How many per day? ____________________

How much coffee do you drink? _______cups/day Colas _______ number/day

What kind of alcoholic beverages do you usually drink, if any? _____Avg. no. of drinks/week? _____

How much water do you drink per day? _____________________________

Sleep How many hours do you sleep in general? ___________ Bedtime from _______to ________

☐ wake up at night, how many times? ___________ ☐ Dream disturbed sleep

Exercise Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise? ______________________________

How long/ often? ________________

Diet Are you a vegetarian? ☐ Yes ☐ No ☐ Yes, but not so strict

Do you eat a lot of spicy food? ☐ Yes ☐ No

☐ ***Please check if you have or have had (in the last three months) any of the following diseases or conditions.***

Pain **Pain Level __________ (from 1 to 10, with 10 being the worst pain ever)**

Worse with ☐ Worse at night ☐ Worse in the morning ☐ Worse in the afternoon
☐ Movement ☐ with Stress ☐ with Pressing ☐ with___________position ☐ Other________

Frequency ☐ Constant ☐ Comes and goes ☐ Other___________________

Location ☐ Fixed Location ☐ Moving ☐ Raditate from___________to __________

Character ☐ Sharp ☐ Dull ☐ Tight ☐ Aching/Sore ☐ Burning ☐ Numbness ☐ Other___________

General ☐ Fatique ☐ Poor appetite ☐ Poor memory ☐ Poor Sleep ☐ Tremors ☐ Bitter taste in the mouth
☐ Excess sweats ☐ Night sweats ☐ Sweat easily ☐ Heat Intolerance ☐ Thirst ☐ Sore Throat
☐ Dryness ☐ Jaundice ☐ Bleed or bruise easily ☐ Cold Intolerance ☐ Cold hands /feet
☐ Weight loss ☐ Weight gain ☐ Chill ☐ Fever

Skin & hair ☐ Acne ☐ Dry skin ☐ Rashes ☐ Ulcerations ☐ Eezema ☐ Loss of hair ☐ Other______________

Musculoskeletal ☐ Muscle spasm ☐ Muscle weakness ☐ Edema ☐ Spinal curvature ☐ Hernia ☐ Paralysis

Eyes, ears, nose, mouth

☐ Poor vision ☐ Eye strain ☐ Blurry vision ☐ Night blindness ☐ Color blindness
☐ Poor hearing ☐ Ringing in the ears ☐ Sinus problems ☐ Nose bleeding
☐ Teeth problems ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other _________________

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Fainting ☐ Palpitation ☐ Color blindness
☐ Irregular heart beat ☐ Rapid heart beat ☐ Varicose veins ☐ Other_______________________

Respiratory

☐ Cough ☐ Wheezing ☐ Coughing blood ☐ Short of breath ☐ Pneumonia
☐ Bronchitis ☐ Other _____________________

Gastrointestinal

☐ Nausea/ Vomiting ☐ Belching /Hiccup ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Blood in the stool ☐ Loose stool ☐ Indigestion ☐ Bad breath ☐ Belching /Hiccup
☐ Parasites ☐ abdominal pain/cramps ☐ Gallbladder programs ☐ Other_________________
Bowel movements: Frequency (per day or per week)___________________

Neuro-psychological

☐ Depression ☐ Anxiety ☐ Loss of balance ☐ Lack of coordination ☐ Bad temper
☐ Loose stool ☐ PTSD ☐ Bi-polar ☐ Other________________

Genital-urinary

☐ Frequent urination ☐ Painful urination ☐ Blood in urine ☐ Dribbling
☐ Urgency to urine ☐ Pause of flow ☐ Kidney stones ☐ Frequent urinary tract
☐ STD ☐ Other_________________

Female ☐ Fibroids ☐ Irregular period ☐ Amenorrhea or scanty menstruation
☐ Pelvic infection ☐ Modiness related to periods ☐ Pain/cramps related periods
☐ Fertility problems ☐ Hot flashes ☐ Other__________________________

Male ☐ Postate problems ☐ Ectile dysfunction ☐ Ejaculation problems ☐ Other______________

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Acaciawood Acupuncture Clinic is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C>S article 4495b, governing the practice of acupuncture)

▶ **I (patient's name)________________________am notifyin`g the Acaciawood Acupuncture Clinic of the following:**

__Yes __No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

__Yes __No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is , and the most recent date of treatment prior to acupuncture treatment is . After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___Chronic Pain ___Smoking addiction ___Weight loss ___Alcoholism ___Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

▶ ________________________________ ▶ ______________________

PATIENT SIGNATURE REQUIRED **DATE**

Acaciawood Acupuncture Clinic is not responsible for untrue statements made by patient

ACUPUNCTURE INFORMED CONSENT TO TREAT

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.

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.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including 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 spontaneous miscarriage, 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 effectsand 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

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.
By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:: **Joshua Li**

▶ PATIENT PRINT NAME:______________________________

▶ PATIENT SIGNATURE:______________________________ Date: ______________________

(Or Patient Representative Signature)