Acupuncture Intake

Full Name: _____

Present illness/injury/or concern

Please describe the health problem(s) for which you are seeking treatment. Please include whether you have received a medical diagnosis, when it began, and if anything has made it better or worse.

_____

_____

Medical History

Indicate any significant illness(es) you have or have had in the past:

☐ Cancer	☐ Bleeding Disorder	☐ Tuberculosis
☐ High Blood Pressure	☐ Blood Disorder/Anemia	☐ Breathing Problems
☐ Heart disease	☐ Hepatitis _____	☐ Rheumatic Fever
☐ Stroke	☐ HIV/AIDS	☐ Autoimmune Disorder
☐ Diabetes	☐ Venereal Disease	☐ Seizures
☐ Digestive Disorder	☐ Emotional Disorders	☐ Other: _____

Family History

Have any of your blood relatives had any of the following?

☐ Stroke	☐ Bleeding Disorder	☐ Thyroid Disorder
☐ Heart Disease	☐ Blood Disorder	☐ Kidney Disease
☐ High Blood Pressure	☐ Cancer	☐ Diabetes

General Health

When was your last physical exam? Where any abnormalities found? (If so please explain)

_____

Please indicate the use and frequency of the following:

☐ Tobacco_____ ☐ Coffee/Black tea_____ ☐ Alcohol _____

What types of exercise do you do during the week? How often and for what duration?

_____

How many hours per week do you work? Do you work sitting, standing, mixed, heavy labor?

_____

Please give a brief description of what you eat and drink on a typical day, including times of consumption.

_____

_____

On average, how many hours do you sleep each night? Any difficulty falling or staying asleep?

_____

Women:

Age of your first period: _____

Length of flow (days): _____

Length of menstrual cycle: _____

Number of pregnancies: _____

Number of live births: _____

Are you pregnant or is it possible: _____

Any abnormal vaginal discharge (Circle): Yes No

If yes, what color is it: _____

Date of last gynecological checkup: _____

Was everything normal? (If not, please explain)

_____

Date of last period: _____

Do you have a history of any of the following?

☐ Menstrual Cramps	☐ Vaginal Yeast Infections	☐ Infertility/Difficulty Getting Pregnant
☐ Excessive Bleeding	☐ Abnormal Pap Smear	☐ Difficulty Staying Pregnant
☐ Spotting	☐ Breast Swelling/Tenderness	☐ Breast Cysts
☐ Irregular Cycle	☐ History Of Hormone Therapy	☐ Endometriosis
☐ Menstrual Blood Clots	☐ Ovarian Cysts	☐ Hysterectomy
☐ Emotional Changes With Period	☐ Hot Flashes	☐ Other: _____
☐ PMS	☐ Vaginal Dryness	

Check here if you do not want to discuss or treat the above conditions ☐

Men:

Do you have a history of any of the following?

☐ Painful/Swollen Testicles	☐ Erectile Dysfunction	☐ Infertility
☐ Night Ejaculation/Problems	☐ Prostate Problems	☐ Other _____

Check here if you do not want to discuss or treat the above conditions ☐

Symptom Survey

Please indicate if you have had ***(in the last three months)*** any of the following:

General

□ Poor appetite □ Poor sleep □ Fatigue □ Stress □ Fevers □ Chills □ Night sweats Sweat easily □ Tremors
□ Cravings □ Change in appetite □ Poor balance □ Localized weakness □ Weight loss □ Weight gain
□ Peculiar tastes □ Desire for hot food □ Desire for cold food □ Strong thirst (hot or cold drinks)

Skin & Hair

□ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples □ Acne □ Dandruff □ Dry skin □ Recent moles
□ Obvious change in a mole or wart □ Purpura □ Change in hair of skin texture □ Warts □ Jaundice
□ Other _____

Musculoskeletal

□ Joint disorders □ Muscle weakness □ Pain/soreness in the muscles □ Fibromyalgia □ Tremors
□ Cold hands/feet □ Difficulty walking □ Swelling of hands/feet □ Spinal curvature □ Back pain □ Hernia
□ Numbness □ Tingling □ Paralysis □ Neck tightness □ Neck pain □ Shoulder pain □ Hand/wrist pain □ Hip pain
□ Knee pain □ Joint sprain □ Other _____

Head, eyes, ears, nose, and throat

□ Dizziness □ Concussions □ Migraines □ Glasses/lens □ Eye strain □ Eye pain □ Color blindness □ Poor vision
□ Cataracts □ Blurry vision □ Spots in front of eyes □ Earaches □ Ringing in ears □ Poor hearing
□ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain □ Jaw clicks
□ Sores on lips/tongue □ Difficulty swallowing □ Other _____

Cardiovascular

□ High blood pressure □ Low blood pressure □ Chest pain □ Palpitations □ Fainting □ Irregular heartbeat
□ Rapid heartbeat □ Phlebitis □ Varicose veins □ Other _____

Respiratory

□ Cough □ Coughing blood □ Production of phlegm (What color?)_____ □ Wheezing □ Difficulty breathing
□ Chest pain □ Asthma □ Emphysema □ Hoarseness □ Bronchitis □ Pneumonia □ Other _____

Gastrointestinal

□ Nausea □ Vomiting □ Diarrhea □ Constipation □ Chronic laxative use □ Change in bowl habits □ Gas
□ Irritable Bowel Syndrome □ Belching □ Indigestion □ Colitis □ Acid reflux □ Peptic ulcer □ Bad breath
□ Black stools □ Blood in stools □ Rectal pain □ Hemorrhoids □ Abdominal pain/cramps □ Parasites
□ Gallbladder problems □ Other _____
Bowel movements:
Frequency:_____ Color:_____ Foul Odor: Y/N Texture/form: Loose/Formed/Small Pieces/Dry

Neuro-psychological

□ Loss of balance □ Lack of coordination □ Concussion □ Depression □ Anxiety □ Stress □ Bad temper □ Bi-polar
□ ADHD/ADD □ Worry easily □ Tendency to become obsessive □ Other _____

Genito-urinary

□ Painful urination □ Frequent urination □ Blood in urine □ Abnormal discharge □ Urgency to urinate
□ Change in bladder habits □ Kidney stones □ Unable to hold urine □ Dribbling □ Pause of flow □ STD's
□ Frequent urinary tract infection □ Genital pain □ Genital itching □ Genital rashes □ Low Sexual Drive
□ Excessive Sexual Drive □ Other _____

I have completed this form correctly to the best of my knowledge.

Signature:_____ ☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Date: _____

Hands On Healing
Traditional Chinese Medicine

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirement of section 183.7(e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient's name),_____am notifying the practitioner, Amber Wells, L.Ac. of **one of the four** following:

☐ Yes ☐ No I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician or dentist should evaluate me for the condition being treated by the acupuncturist.

_____ _____

(Patient Signature) (Date)

OR

☐ Yes ☐ No I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is_____, and the most recent date of chiropractic treatment prior to acupuncture treatment is_____. After being referred by a chiropractor, if after 60 days or 20 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 to follow this advice.

_____ _____

(Patient Signature) (Date)

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 one of the following conditions:

☐Chronic Pain

☐Weight Loss

☐Smoking Cessation

_____ _____

(Patient Signature) (Date)

OR

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow her advice.

_____ _____

(Patient Signature) (Date)

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/rare 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 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. 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: Amber Wells, L.Ac.

PATIENT SIGNATURE: **X** DATE:

Hands On Healing

Summary Of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data.
IMPORTANT NOTE: This does not include all of the details about our privacy policy. For complete details, please read the NOTICE OF PRIVACY PRACTICES that is available in our office.

I. How we may use and share health data about you:
a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have need your consent:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities (if you are an organ donor)
i) To avert a threat to an individual or to public health safety

III. Disclosures where your consent is required:
a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full NOTICE OF PRIVACY PRACTICES document from Hands On Healing at any time.

_____
Patient Name (Print)

_____ _____
Patient Signature Date signed