CENTER FOR ACUPUNCTURE AND ACUPRESSURE INTAKE FORM

Name_____ Today's Date _____

Address & Zip Code_____

Cell Phone #_____ Home Phone _____

Work Phone #_____Email _____

Emergency Contact Person _____ Relationship _____

Emergency Contact Person's Phone_____

How did you hear about this Center?_____

Your Birth Date_____ Occupation _____

Single/Married/Partnered/Separated/Divorced (circle one). Number of children_____ Age _____

Level of stress in your life from 1 (min) to 10 (max)_____

What are the main stress factors in your life? _____

_____

List all medications you are taking & specify reason/s for taking_____

_____

_____

_____

What other illnesses or imbalances do you have now or in the past (circle)?:

acid reflux (GERD), Aids/HIV, alcoholism/drug abuse, allergies, anemia, arthritis (osteo/rheumatoid), asthma/bronchitis, bad breath, bloating, blood clotting disorder, cancer/tumor, chronic fatigue syndrome, concussion, constipation, depression, diabetes, diarrhea, dizziness, ear problems (deafness, tinnitus), eating disorder, eczema, emphysema, eye problems (floaters, dry eye, etc.), fibroids, fibromyalgia, frequent colds or infections, gallstones, heart disease, hemorrhoids, hepatitis A/B/C, herpes, hernia, hypertension, hypoglycemia, insomnia, irritable bowel (IBS), kidney stones or disease, lyme disease, mitral valve prolapse, mood disorder, multiple sclerosis, nosebleeds, osteoporosis, pacemaker, parkinson's disease, pelvic inflammatory disease, polio, psoriasis, PTSD, rheumatic or scarlet fever, rosacea, scoliosis, seizures or epilepsy, shingles, sinus problems, stroke, schizophrenia, thyroid disease, TMJ dysfunction, tuberculosis, trigeminal neuralgia, urinary tract infections, OTHER:

List all surgeries and hospitalizations (major & minor) you've had (include dates):_____

_____

_____

_____

List all physical traumas you've experienced (i.e. sports injuries, auto accidents, physical abuse) w/dates:

_____

_____

_____

_____

Please describe your frequency/quantity of use of the following substances:

Nicotine/Tobacco _____ Marijuana _____

Alcohol _____

Coffee/Caffeine _____ Soft Drinks _____

Sugar _____

Other Substance/Habit _____

Would you like cut down on or eliminate the use of any substance now or in the future? Please explain:

_____

List any health issues that are prevalent in your family, such as alcoholism, mental illness, asthma, heart disease, cancer, alzheimer's disease, diabetes, osteoporosis, joints requiring replacement, etc:

_____

What are the main problems you would like help with in order of importance (in descending order)?:

1) _____

2) _____

3) _____

WOMEN ONLY

Are you, or could you be pregnant? _____ If so, how far along? _____
Number of pregnancies _____ Births _____ Abortions _____ Miscarriages _____
Complications with labor/delivery?

_____
What form of birth control do you use? _____
Age of first menses _____Age of menopause, if applicable _____
Do you bleed between periods? _____ Bleed after intercourse?_____
Do you have: Endometriosis _____ Fibroids _____ PCOS _____ Cystic or lumpy breasts _____
Abnormal findings on any tests? _____ Hot flashes or night sweats _____
Are your periods uncomfortable or painful, either emotionally or physically? _____ If yes, explain:

_____
Are your periods:
Regular (25-32 days apart)____Mostly Short (< 24 days)____ Mostly Long (>33 days)____Varied ____
Do you bleed heavily (i.e. need more than 1 pad or tampon at a time, need to change during the night, need to change pads every hour or so, gushing)? _____ Do you bleed an average amount? _____
Do you bleed lightly (i.e. just spotting)? _____ How many days do you bleed? _____
Do you have clots? _____ Are the clots larger than a quarter? _____ Relative to the blood that comes from a wound, is your menstrual blood: The same color _____More pale_____ Purple_____
More red_____ More brown _____. Do you suffer from PMS? _____. PMS symptoms:

_____

Are you experiencing any low or high sexual desire?_____ Is this a problem? _____

Menopausal symptoms? _____ Describe _____

Do you have any other gynecological concerns or complaints? _____

_____

MEN ONLY

Do you experience any of the following (check all that apply)?:
Reduced Libido _____ Excessive Libido_____ Impotence _____
Urinary Frequency or urgency _____ Urinary Difficulty or Hesitancy _____
Premature Ejaculation _____Genital/ Testicular pain_____ Discharge _____

Any other concerns?_____

Informed Consent to Oriental Medicine

I hereby request and consent to the performance of acupuncture, and other procedures within the scope of the practice of Oriental Medicine, on me (or the patient named below for whom I am legally responsible) by Abby Kessler, Lic. Ac. I understand that methods of treatment may include, but are not limited to, acupuncture; moxabustion; cupping; guasha (scraping therapy); needle retention; acupressure and/or shiatsu; electrical, laser, and/or magnetic stimulation; mild bleeding therapy; diagnostic palpation on various areas of my body; Chinese herbal medicine; and nutritional and/or lifestyle counseling. I understand that the herbal prescriptions may need to be prepared and that the resulting teas (decoctions) be consumed according to the instructions provided.

I understand and am informed that in the practice of Oriental Medicine, as in the practice of allopathic medicine, there are some side effects and/or risks of treatment; I understand that although these are unlikely to occur, they are possible. Some of these effects include, but are not limited to: bleeding; bruising, numbness, tingling, pain or other strong sensation at the location where a needle is inserted or radiating from that location; aggravation of current symptoms; appearance of new symptoms; general aches or dizziness. Bruising is a common side effect of guasha and cupping. Burns and/or scarring are a potential risk of moxabustion. Unusual risks of acupuncture include nerve pain; organ puncture, or spontaneous miscarriage. Infection is another possible risk, although the acupuncturist uses sterile, single-use, 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.

Herbs, (which are derived from plant, animal and mineral sources) that are recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea, headache, rashes and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy and will immediately notify the acupuncturist(s) if I know or suspect that I am pregnant. Further, I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of any Chinese herbs.

I do not expect the acupuncturist(s) to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist(s) to exercise such judgment based on the known facts, during the course of my treatment, to be in my best interest. I understand that results are not guaranteed.

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 benefits and risks of acupuncture treatments 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 from this clinic.

Patient's name (print) _____ Signature _____ Date _____

Legal Guardian's name (print) _____ Signature _____ Date_____

Cancellation Policy

Please show up on time wearing loose comfortable clothing that can be rolled up above the elbows and knees. The charge for an appointment cancelled less than 24 hours, but more than 6 hours before the scheduled time is 50% of the cost of the treatment. The charge for no shows and cancellations made less than 6 hours before the scheduled appointment is 100% of the cost of the treatment. The only exceptions are: 1) Patient or his/her child has a fever, or medical emergency requiring immediate hospitalization or emergency intervention; or, 2) Severe weather emergency causing the closing of local schools and public buildings. Note: The common cold is effectively treated with acupuncture. Please sign below that you have read and understand our cancellation policy:

Patient's name (signature) _____ Date _____