Acupuncture Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Patient Information (Please Print)

Name: _____ Date of First Visit: _____

Date of Birth: _____ M / F Occupation: _____

Address: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Email Address _____ Preferred method of contact: Home Cell E-Mail

Family Doctor: _____ Phone _____

Emergency Contact Name: _____ Phone: _____

How did you hear of us? _____

Have you ever had Acupuncture before? YES NO

What is your primary reason(s) for treatment today?

_____

_____

_____

Have you visited a medical doctor for this condition? YES NO

If yes, did you receive a diagnosis? NO YES: _____

Are you currently receiving any other treatments for this condition? YES NO

If yes, please describe treatments and how effective they have been: _____

_____

_____

Please list any current medications (prescription and over the counter), vitamins, supplements, herbs or homeopathic remedies that you are taking, including dosage if you know it

_____

_____

_____

_____

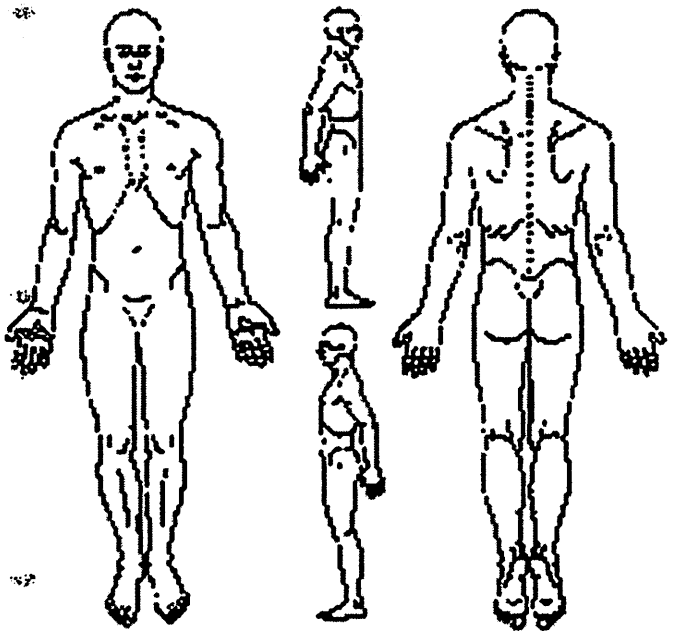
For females: Are you pregnant? NO Possibly YES How far along? _____

Do you have a contagious disease at this time? NO YES: _____

If you are seeking treatment for a painful condition, please describe the pain and shade in areas of pain on the diagram below

Pain Condition #1 *Degree of pain* (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

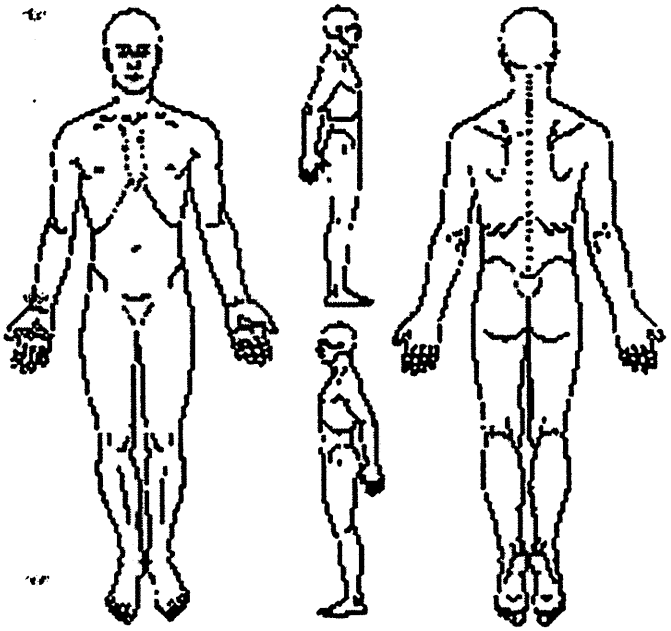
Nature of the Pain
- O Constant
- O Comes and goes
- O Fixed
- O Moves
- O One side
- O Both sides
- O Sharp
- O Dull
- O Burning
- O Aching
- O Spastic
- O Numb



Does the pain get better, or worse with?
- O Heat *better worse*
- O Cold *better worse*
- O Motion *better worse*
- O Rest *better worse*
- O Pressure *better worse*
- O Better in *AM* or *PM*?

Pain Condition #2 *Degree of pain* (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain
- O Constant
- O Comes and goes
- O Fixed
- O Moves
- O One side
- O Both sides
- O Sharp
- O Dull
- O Burning
- O Aching
- O Spastic
- O Numb



Does the pain get better, or worse with?
- O Heat *better worse*
- O Cold *better worse*
- O Motion *better worse*
- O Rest *better worse*
- O Pressure *better worse*
- O Better in *AM* or *PM*

Do you have any of the following?

O Pacemaker
O Surgical replacements
O Implants
O Hemophilia
O Sensitive skin
O Fear of needles
O Latex allergy
O Nut allergy
O Other allergy _____

Is There Family History of:

O Alcoholism
O Allergies
O Asthma
O Bleeding disorders
O Cancer
O Depression
O Diabetes
O Heart disease
O High blood pressure
O Kidney disease
O Mental illness
O Seizures
O Stroke
O Other_____

How much do you consume per day of:

Water _____ Coffee _____ Tea _____ Soda _____ Alcohol _____ Cigarettes _____

Generally, do you prefer □ warm drinks □ cold drinks □ room temperature drinks?

Do you find that you are □ always thirsty □ rarely thirsty or □ thirsty for sips later in the day?

What are your typical eating habits?

O Skip Meal(s)_____
O Eat in a Rush
O Eat When Not Hungry
O Eat too Fast
O Cannot eat when Worried/Stressed
O Excess Hunger
O No Desire to Eat
O Eat late at night
O Craving specific food(s)_____
O Other: _____

What are your typical sleeping habits?

O Hours slept/night _____
O Fall asleep quickly
O Trouble falling asleep
O Difficulty waking up
O Trouble staying asleep
O Deep sleeper
O Light sleeper
O Frequent dreaming
O Disturbing dreams
O Wake at same time every night _____
O Other _____

How would you describe your energy levels?

O High
O Low
O Normal
O Lethargic
O Hyperactive
O Changes from day to day
O Other _____

Do you have aversion to any of the following?

O Cold
O Wind
O Dampness
O Heat
O Loud Noises
O Crowds
O Other _____

What is your Average Body Temperature?

O Hot
O Cold
O Cold Hands & Feet
O Hotter @ Night
O Colder @ night
O 5 Center Heat
O Hot Joints
O Other _____

General Information

- O Anorexia/Bulimia
- O Chronic Fatigue
- O Chicken Pox
- O Chronic Pain
- O Fibromyalgia
- O Hepatitis _____
- O HIV
- O Herpes/Cold Sores
- O Cancer: _____
- O Other: _____
- O Lupus
- O Lyme disease
- O Meningitis
- O Scarlet Fever
- O Mononucleosis
- O Multiple Sclerosis
- O Rheumatoid Disease
- O Rheumatic Fever
- O Mumps
- O Tuberculosis
- O Thyroid Disease
  - o Overactive
  - o underactive
- O Measles
- O Pneumonia
- O Tonsillitis

Head, Eyes, Ears, Nose and Throat

- O Bitter taste
- O Blurred vision
- O Cataracts
- O Concussions
- O Dry mouth / nose
- O Ear aches
- O Excess phlegm
- O Eye pain or strain
- O Facial pain
- O Glasses or contacts
- O Glaucoma
- O Other: _____
- O Grinding of teeth
- O Goiter
- O Gum problems
- O Headaches
- O Hearing aids
- O Itchy eyes
- O Migraines
- O Nose bleeds
- O Poor hearing
- O Red or dry eyes
- O Ringing in ears
  - o High pitch
  - o Low pitch
- O Sinus issues
- O Spots in eyes
- O Swollen glands
- O Teeth issues
- O TMJ Syndrome
- O Trigeminal neuralgia
- O Watery eyes

Respiratory:

- O Asthma/Wheezing
- O Frequent colds
- O Allergies
- O Bronchitis
- O Cough
- O Other: _____
- O Cough + Phlegm
- O Emphysema
- O Heavy Chest
- O Pneumonia
- O COPD
- O Cough + blood
- O Difficult breathing
- O Tight Chest
- O Short of Breath

Cardiovascular:

- O Anemia
- O Arteriosclerosis
- O Easily bruised
- O Poor circulation
- O Blood clots
- O Heart Disease: _____
- O Other: _____
- O Fainting
- O High cholesterol
- O Low blood pressure
- O Palpitations
- O Chest pain
- O High blood pressure
- O Irregular heart beat
- O Pace maker
- O Phlebitis
- O Stroke

Gastrointestinal

- O # Bowel Movements/day___
- O Normal Stool
- O Loose stool
- O Constipation
- O Diarrhea
- O Undigested food in stool
- O Mucous in stool
- O Blood in stool
- O Strong odour
- O Pain before BM
- O Other: _____
- O Pain after BM
- O Heartburn/acid reflux
- O Abdominal pain
- O Appendicitis
- O Bloating
- O Celiac Disease
- O Gas
- O Hiccups
- O Nausea/vomiting
- O Bad breath
- O Rectal pain/itching
- O Hemorrhoids
- O Hernia
- O Liver Disorder
- O Ulcer
  - o H. Pylori Negative
  - o H. Pylori Positive
  - o Not Tested

Genito-Urinary

- O Bed wetting
- O Bladder infections
- O Bloody urine
- O Frequent urination
- O Painful urination
- O Incomplete urination
- O Incontinence
- O Urgent urination
- O Wake to urinate
- O Pale urine
- O Dark urine
- O Cloudy urine
- O Kidney stones
- O Kidney Disease
- O Libido issues
- O Yeast infection
- O Impotence
- O Prostate Disorder
- O Premature ejaculation
- O Nocturnal emissions
- O Other: _____

Gynecological

- O Menopause
- O Oral Birth control pills
- O Intra-Uterine Device IUD
- O Breast lumps
- O Genital burning
- O Genital itching
- O Genital discharge
- O Genital swelling
- O Hysterectomy
- O Endometriosis
- O Fibroids
- O Cysts
- O PMS – headaches
- O PMS – back aches
- O PMS – mood swings
- O # Pregnancies _____
- O # Miscarriages_____

Menstruation Information:

- O Heavy periods
- O Light periods
- O Irregular periods
- O Pain Before
- O Pain During

Describe the menstrual blood:

- O Pain After
- O Dark Red
- O Bright Red
- O Pale Red
- O Brownish
- O Thin/Watery
- O Very thick
- O Clots?
  - o Size _____
  - o Color _____

Days between periods _____ # days of period_____

Other Information: _____

Skin and Hair

- O Acne
- O Burning skin
- O Dandruff
- O Dermatitis
- O Discolorations
- O Eczema
- O Fungal infection
- O Hair loss
- O Hot flashes
- O Heavy sweating
- O Not able to sweat
- O Hives
- O Itchy/dry skin
- O Psoriasis
- O Rashes
- O Shingles
- O Warts
- O Other: _____

Neuro-Psychological

- O ADD/ADHD
- O Addiction
- O Anxiety
- O Depression
- O Easily stressed
- O Epilepsy
- O Irritability
- O Mental illness
- O numbness
- O "Foggy" feeling
- O Poor coordination
- O Parkinson's Disease
- O Poor memory
- O Seizure
- O Vertigo/Dizziness
- O Other: _____

Musculoskeletal:

- O Osteoarthritis
- O Rheumatoid arthritis
- O Atrophy
- O Body heaviness
- O Joint pain
- O Limited motion
- O Limited use
- O Back pain
- O Muscle pain
- O Muscle cramps
- O Neck pain
- O Rib pain
- O Scoliosis
- O Weight gain
- O Weight loss
- O Broken Bones: _____
- O Other: _____

Hudson Family Chiropractic & Physical Therapy

ACUPUNCTURE INFORMED CONSENT

"Acupuncture" means the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles to prevent or modify the perception of pain or to normalize physiological functions including pain control and for the treatment of disease of dysfunctions of the body. I hereby consent to acupuncture treatments and related procedure, associated with Oriental Medicine, on me (or the patient whom I am legal responsible) by the acupuncturist. I have discussed the nature and purpose of my treatment. I understand that methods of treatment may include but are not limited to acupuncture, bleeding, moxibustion, cupping, gua sha, tuina (Chinese massage), electrical stimulation, mechanical stimulation, Eastern nutritional recommendations (Oriental dietary therapy) and herbology.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness, or tingling near the needle sight that may last a few days, with dizziness or fainting, and aggravation of problematic symptoms existing prior to treatment. A common side effect of cupping and gua sha are bruising and/or discolored skin. Burns and scarring are potential risks of using moxibustion. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung (pneumothorax). Infection is another possible risk, however since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand that everyone responds to treatment differently. No guarantee is made concerning the outcome of treatment.

I understand that the practitioner and administrative staff may review my medical records and reports, but all of my medical records will be kept confidential and will not be released without my written consent.

I will notify the Acupuncturist, who is caring for me, if I am pregnant.

By voluntarily signing below, I know that I have read or have had read to me, this consent to treatment. I 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 both the present condition and for any future conditions for which I seek treatment(s).

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

While Chinese Medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is "recommended" that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s). This is a recommendation ONLY. The state of NJ DOES NOT require a MD prescription for acupuncture.

I, (print name), _____ have been advised by Hudson Family Chiropractic and Physical Therapy and Acupuncture, to consult a physician regarding the conditions, for which I seek acupuncture and/or Chinese Herbal Medicine.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE