Brandy Lynn, MAcOM, L.Ac.
www.brandylynnacupuncture.weebly.com

Acupuncture Intake Form

Chinese Medical Diagnosis requires thorough, honest feedback from the client. The accuracy of the information provided will directly benefit the effectiveness of your treatments. Thank you for taking the time to complete this form to the best of your ability.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Gender: M F

Best phone # to contact you at:_____

e-mail address_____

In case of emergency contact_____

Phone_____ Relationship_____

Please describe the reason for your visit
today (Chief Complaint)

_____

Is it getting better, worse, or staying the same?

_____

Are you, or have you been, treated for this problem with any other health professionals?

_____

Has it been effective?

_____

What was your diagnosis?

_____

Are you taking any medication or herbal supplements? If so, which ones? (Include dosage if known)

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MEDICAL HISTORY

Please circle any current health issue. For those diseases which are part of your health history, please note the year of the occurrence.

Allergies
Anemia
Appendicitis
Arteriosclerosis
Asthma
Autism/ Asperger's/ ASD
ADD/ OCD
Bleeding Disorder
Blood Pressure (Low or High)
Cancer
Chicken Pox
Diabetes
Digestive Disorders
Emotional Difficulties
Emphysema
Epilepsy
Fatigue
Gout
Heart Disease
Hepatitis (A, B,C)
Hypoglycemia
Injuries
Insomnia
Intestinal Parasites
Multiple Sclerosis
Mumps
Pacemaker
Polio
Scarlet Fever
Stroke
Thyroid Disorder
Trauma (falls, accidents)
Tuberculosis
Ulcers
Weight Loss or Gain
Other_____

Please list any surgeries or medical procedures with dates:

Do any of your family members suffer from: (Please list relationship to you)

Alcoholism
Allergies (list)
Cancer
Diabetes
Arteriosclerosis
Asthma
Seizures
Stroke
Heart Disease
High Blood Pressure

Which of the following list are included of your lifestyle? List frequency/ quantity:

Alcohol
Coffee
Nicotine
Recreational Drug Use
Exercise
Excessive Sugar

Do you usually eat three meals a day? _____Do you follow any particular diet?_____

Do you have any known food allergies or sensitivities?

On the scale of 1-10, how would you rate the level of stress in your life currently?

What is the level of stress in your life in general (1-10)?

How does stress affect you? (ie, more headaches, stomach pain, etc.)

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REVIEW OF SYSTEMS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! If you're currently experiencing the symptom circle it, if you have experienced it in your past, please put a check by it.

Head and Face
Headaches
Dizziness
Memory Loss
Other

Eyes
Blurry Vision
Eyelid Twitching
Floaters
Pain

Nose
Frequent Colds
Sinus Trouble
Bleeding

Mouth
Dental Problems
Gum Problems
Teeth Grinding/TMJ
Unusual Tastes
Other

Throat
Sore Throat
Hoarseness
Difficulty Swallowing
Dryness
Other

Respiration
Difficulty Inhaling
Difficulty Exhaling
Pain
Cough
Congestion
Shortness of Breath
Other

Heart and Chest
High Blood Pressure
Low Blood Pressure
Chest Pain
Chest Tightness
Difficulty Lying Down
Heart Palpitations

Circulation
Easy Bruising
Easy Bleeding
Cold Limbs-Hands or Feet
Reynaud's Syndrome

Gastrointestinal
Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain
Nausea
Diarrhea/Loose Stools
Constipation
Rectal Bleeding
Colon Problems

Urination
Frequent
Difficult
Painful
Nocturnal
Bleeding
Other

Skin
Acne
Dryness
Moles that Change
Lumps
Excessive Sweating
Night Sweats
Rarely Sweat
Other

Neurological
Nervousness/Anxiety
Tremors
Numbness or Tingling
Lack of Coordination
Nerve Pain
Other

Sleep
Insomnia
Drowsiness
Excessive Dreaming
Waking Easily
Other

Pain - Please Describe
_____
_____
_____
_____

Are there any other health concerns you'd like to address?
_____
_____

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Do you currently or have you ever had a menstrual cycle? Y or N
If no, please continue to the next page~

Are you, or could you be pregnant?_____If so, how far along?_____
Number of pregnancies_____ Births_____ Abortions_____Miscarriages_____
What form, if any, of birth control do you use?_____
Age of first menses_____ Age of menopause, if applicable_____
Do you bleed between periods?_____
Have you ever had any gynecological surgeries or any abnormal findings on any tests?
_____
_____

Are your periods uncomfortable or painful, either emotionally or physically?_____
Are your periods:

Short (< 28 days)_____Long (30+ days)_____
Average_____(28-30days) Varied_____
Painful? If so, Before_____ During_____ After_____
Quality and location of pain_____
Do you bleed heavily_____? Lightly_____? Very little?_____
Do you have clots ?_____ Early in the cycle_____ or throughout?_____
Relative to the blood that comes from a wound, is your menstrual blood:
Similar color_____Pale_____ Purple_____ Bright Red_____
Dark Red_____ Brown_____ Black_____
How many days do you bleed?_____

Do you have any of the following Pre-Menstrual Symptoms?
Please keep in mind that, in Chinese medical theory, emotions are paired with organs and channels; Your accuracy and honesty can be essential to diagnosis and an individualized treatment plan

Irritability____ Depression_____ Crying_____ Rage_____ Nausea_____
Cravings, and if so for what?_____Breast Tenderness_____
Irrational thought or behavior_____

Do you have any other gynecological concerns or complaints?
_____
_____
_____

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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 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.

PATIENT SIGNATURE X_____DATE_____
(Or Patient Representative) (Indicate relationship if signing for patient)