Full Motion LIFE & SPORT

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Acupuncture New Patient Intake Form

During your first visit or consultation we hope to come to understand your health concerns, answer questions you may have and give you an examination or consultation using the Oriental medical approach. Then we will review the results together and look at options available for treatment of your condition. If you elect to undertake treatment, we will begin as soon as possible. Treatment often begins at one's first visit. Your treatment with us is meant to compliment and not replace your regular visits to your Primary Care Practitioner, or traditional Western (allopathic) medicine provider.

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Name:_____ Home #:_____

Address:_____ Work #:_____

City:_____ State:_____ Zip:_____ Email:_____

Date of Birth:_____ Age:_____ If under 18, person responsible for your account:_____

Emergency Contact:_____ Contact Phone #:_____ Referred to our clinic by:_____

Have you ever tried acupuncture therapy before? ❑ Yes ❑ No If yes, with whom?_____

Are you interested in additional health services besides acupuncture? ❑ Yes ❑ No

If yes, please check which services you might be interested in: ❑ Chiropractic Services ❑ Chinese Herbal Medicine

❑ Therapeutic Massage ❑ Assisted Stretching/Yoga ❑ Relaxation Techniques ❑ Tai Chi and/or Qi Gong Health Exercises

❑ Relaxation Techniques ❑ Nutritional Consultation ❑ Other:_____

Please indicate if any of the following pertain to you:
(Note: Marking "Yes" does not make you ineligible for treatment; however, it may restrict some of our treatment modalities)

❑ Hepatitis ❑ HIV ❑ High Blood Pressure ❑ Seizures ❑ Pacemaker ❑ Blood-thinning Meds ❑ Pregnancy

Please indicate the use (amount) and frequency (per day or per week) of the following:

Coffee:_____ Soda:_____ Water:_____

Alcohol:_____ Recreational Drugs:_____ Tobacco:_____

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason

Health History

What are the health problems for which you are seeking treatment?_____

_____

How long have you had this condition?_____

What other forms of treatment have you sought?_____

What helps your condition?_____

What aggravates your condition?_____

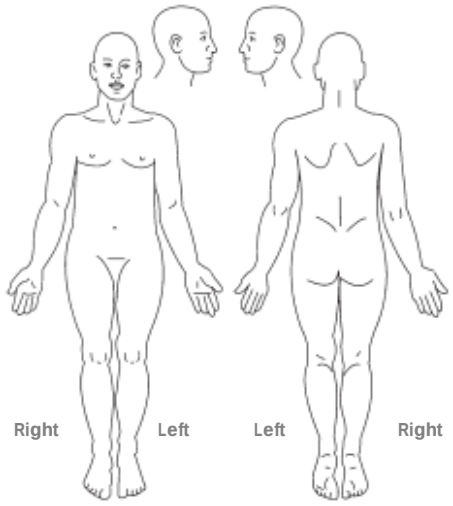
Please list any surgeries or major health incidents (accidents, etc.) in your life:_____

_____

_____

PAIN PATIENTS *(Other patients please skip this section & proceed to Symptom Survey)*

Please indicate on the figures the areas of the body you experience your pain:



How would you characterize your pain?

❑ Dull/Achy ❑ Sharp/Stabbing ❑ Burning

❑ Tingling ❑ Numbness ❑ Electrical

What would you like to achieve with acupuncture treatment?

_____

_____

_____

Symptom Survey

Please "check" the symptoms or conditions you experience frequently:

Sp/St

- ❑ Excessive Appetite
- ❑ Loose Stool/Diarrhea
- ❑ Digestive Problems
- ❑ Vomiting
- ❑ Belching, Burping
- ❑ Heartburn/Reflex
- ❑ Stomach Bloating
- ❑ Obsession in Work
- ❑ Blood in Stool
- ❑ Lack of Appetite
- ❑ Hemorrhoids
- ❑ Easily Bruised
- ❑ I Usually Feel Warm

Ht/P

- ❑ Insomnia
- ❑ Palpitations
- ❑ Cold Hands and Feet
- ❑ Nightmares
- ❑ Mentally Restless
- ❑ Laughing for no Reason
- ❑ Chest Pains
- ❑ Poor Memory
- ❑ Sadness
- ❑ Depression
- ❑ Anxiety
- ❑ I Usually Feel Chilled

Lu/LI

- ❑ Cough
- ❑ Shortness of Breath
- ❑ Decreased Smelling
- ❑ Nasal Problems
- ❑ Skin Problems
- ❑ Claustrophobia
- ❑ Colitis/Diverticulitis
- ❑ Constipation
- ❑ Allergies
- ❑ Asthma
- ❑ Get Sick Easily

Ki/UB

- ❑ Low Back Pain
- ❑ Knee Problems
- ❑ Hearing Impairment
- ❑ Ear Ringing
- ❑ Kidney Stones
- ❑ Decreased Sex Drive
- ❑ Hair Loss
- ❑ Urinary Problems
- ❑ Dental Problems
- ❑ Fatigue
- ❑ Edema

Liv/GB

- ❑ Eye Problems
- ❑ Jaundice
- ❑ Gall Stones
- ❑ Light-colored Stool
- ❑ Soft or Brittle Nails
- ❑ Easily Angered
- ❑ Difficult Relationships
- ❑ Dizziness
- ❑ Headaches
- ❑ Difficulty Making Decisions
- ❑ Difficulty Digesting Oily Foods

Please indicate if the following pertain to you:
(Note: The Symbol "♀" before a question indicates that it is for Women only.)

Kidney Yin Xu

Do you have lower back weakness, soreness or pain?	❑ Yes	❑ No
Do you have ringing in your ears?	❑ Yes	❑ No
Is your hair prematurely gray?	❑ Yes	❑ No
Do you have dark circles under your eyes?	❑ Yes	❑ No
Do you have night sweats?	❑ Yes	❑ No
Are you prone to hot flashes?	❑ Yes	❑ No
Would you describe yourself as "afraid" frequently?	❑ Yes	❑ No
Do you have dizziness?	❑ Yes	❑ No
Do you have knee problems?	❑ Yes	❑ No
♀ Do you have vaginal dryness?	❑ Yes	❑ No
♀ Is your mid-cycle cervical mucus scanty or missing?	❑ Yes	❑ No

Kid Yang Xu

Is your back sore or weak?	❑ Yes	❑ No
Are your feet cold, especially at night?	❑ Yes	❑ No
Are you typically colder than those around you?	❑ Yes	❑ No
Is your libido low?	❑ Yes	❑ No
Are you often fearful?	❑ Yes	❑ No
Do you wake up at night or early in the morning because you have to urinate?	❑ Yes	❑ No
Do you urinate frequently and is the urine diluted and/or profuse?	❑ Yes	❑ No
Do you have early morning loose, urgent stools?	❑ Yes	❑ No
♀ Do you have pre-menstrual low back pain?	❑ Yes	❑ No
♀ Do you have profuse vaginal discharge?	❑ Yes	❑ No
♀ Do you feel cold cramps during your period that respond to a heating pad?	❑ Yes	❑ No

Spleen Qi – Xue – Yang Xu

Are you often fatigued?	❑ Yes	❑ No
Do you have poor appetite?	❑ Yes	❑ No
Is your energy low after a meal?	❑ Yes	❑ No

Do you feel bloated after eating? ❑ Yes ❑ No

Do you crave sweets? ❑ Yes ❑ No

Do you have loose stools, abdominal pain, or digestive problems? ❑ Yes ❑ No

Are your hands and feet cold? ❑ Yes ❑ No

Are you prone to feeling sluggish? ❑ Yes ❑ No

Are you prone to heaviness or grogginess in the head? ❑ Yes ❑ No

Do you have varicose veins? ❑ Yes ❑ No

Are you prone to worry? ❑ Yes ❑ No

Have you been diagnosed with low blood pressure? ❑ Yes ❑ No

Do you sweat a lot without exerting yourself? ❑ Yes ❑ No

Do you feel dizzy or light-headed, or have visual changes when you stand up fast? ❑ Yes ❑ No

Are you often sick, or do you have allergies? ❑ Yes ❑ No

Have you ever been diagnosed with hypothyroid or anemia? ❑ Yes ❑ No

Do you have hemorrhoids or polyps? ❑ Yes ❑ No

♀ Is your menstruation thin, watery, profuse, or pinkish in color? ❑ Yes ❑ No

♀ Are you more tired around ovulation or menstruation? ❑ Yes ❑ No

♀ Do you ever spot a few days or more before your period comes? ❑ Yes ❑ No

♀ Have you ever been diagnosed with uterine prolapse? ❑ Yes ❑ No

♀ Are your menstrual cramps accompanied by a bearing down sensation in your uterus? ❑ Yes ❑ No

Blood Xu

Do you have dry, flaky skin? ❑ Yes ❑ No

Are you prone to getting chapped lips? ❑ Yes ❑ No

Are your fingernails or toenails brittle? ❑ Yes ❑ No

Is your hair brittle or dry? ❑ Yes ❑ No

Do you have diminished nighttime vision? ❑ Yes ❑ No

Are your lips, the inner side of your lower eyelids, or tongue pale in color? ❑ Yes ❑ No

♀ Do you get dizzy or light-headed around your period? ❑ Yes ❑ No

♀ Are you losing hair on your head? ❑ Yes ❑ No

♀ Are your menses scant or late? ❑ Yes ❑ No

Blood Stasis

Do you experience periodic numbness of your hands and feet, especially at night?	❑ Yes	❑ No
Do you have varicose or spider veins?	❑ Yes	❑ No
Do you have red cherry spots (hemangiomas) on your skin?	❑ Yes	❑ No
Do you have chronic hemorrhoids?	❑ Yes	❑ No
Do you have dark spots in your eyes?	❑ Yes	❑ No
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	❑ Yes	❑ No
♀ Does your menstrual blood contain clots?	❑ Yes	❑ No
♀ Have you been diagnosed with endometriosis or uterine fibroids?	❑ Yes	❑ No
♀ Do you have piercing or stabbing menstrual cramps?	❑ Yes	❑ No
♀ Is your menstrual flow ever brown or black in color?	❑ Yes	❑ No
♀ Do you feel mid-cycle pain around your ovaries?	❑ Yes	❑ No
♀ Do you have painful, unmovable breast lumps?	❑ Yes	❑ No

Liver Qi Stagnation

Are you prone to emotional depression?	❑ Yes	❑ No
Are you prone to anger and/or rage?	❑ Yes	❑ No
Are your pupils usually dilated and large?	❑ Yes	❑ No
Do you have difficulty falling asleep at night?	❑ Yes	❑ No
Do you experience heartburn or wake up with a bitter taste in your mouth?	❑ Yes	❑ No
♀ Do you become irritable pre-menstrually?	❑ Yes	❑ No
♀ Do you feel bloated or irritable around ovulation?	❑ Yes	❑ No
♀ Does it feel as if your ovulation lasts longer than it should?	❑ Yes	❑ No
♀ Are your breasts sensitive/sore at ovulation?	❑ Yes	❑ No
♀ Do you experience nipple pain or discharge from your nipples?	❑ Yes	❑ No
♀ Do you have a lot of pre-menstrual breast distention or pain?	❑ Yes	❑ No
♀ Do you become bloated pre-menstrually?	❑ Yes	❑ No
♀ Are your menses painful?	❑ Yes	❑ No
♀ Do you feel your menstrual cramps in the external genital area?	❑ Yes	❑ No
♀ Is your menstrual blood thick and dark, or purplish in color?	❑ Yes	❑ No

Heart (Any Disorder)

Do you wake up early in the morning and have trouble getting back to sleep?	❑ Yes	❑ No
Do you have heart palpitations, especially when anxious?	❑ Yes	❑ No
Do you have nightmares?	❑ Yes	❑ No
Do you seem low in spirit or lacking vitality?	❑ Yes	❑ No
Are you prone to agitation or extreme restlessness?	❑ Yes	❑ No
Do you fidget?	❑ Yes	❑ No
Do you sweat excessively, especially on your chest?	❑ Yes	❑ No

Excess Heat

Are your mouth and throat usually dry?	❑ Yes	❑ No
Are you often thirsty for cold drinks?	❑ Yes	❑ No
Do you often feel warmer than those around you?	❑ Yes	❑ No
Do you wake up sweating or have hot flashes?	❑ Yes	❑ No
♀ Do you breakout with red acne, especially pre-menstrually?	❑ Yes	❑ No
♀ Do you have a short menstrual cycle?	❑ Yes	❑ No
♀ Do you have vaginal irritation?	❑ Yes	❑ No

Dampness

Do you feel tired and sluggish after a meal?	❑ Yes	❑ No
Do you have cystic or pustular acne?	❑ Yes	❑ No
Do you have urgent, bright, or foul-smelling stools?	❑ Yes	❑ No
Are you overweight?	❑ Yes	❑ No
Do you have a wet, slimy tongue?	❑ Yes	❑ No
Does your body feel like a barometer? Can you sense when it will rain?	❑ Yes	❑ No
♀ Does your menstrual blood contain stringy tissue or mucus?	❑ Yes	❑ No
♀ Are you prone to yeast infections and vaginal itching?	❑ Yes	❑ No
♀ Do you have fibrocystic breasts?	❑ Yes	❑ No

♀ **For Women Only**

Age at first period_____ Date of last period_____ Number of children (live births)_____

Number of days between periods (your cycle)_____ Number of days of flow_____

♀ **Check all that apply**

Color of flow: ❑ pale/light red ❑ red ❑ bright red ❑ dark red ❑ dark red/brown ❑ dark red/purple

# of pads/tampons you use per day: 1st day:_____ 2nd day:_____ 3rd day:_____ 4th day:_____

Pain and cramping: ❑ No / ❑ Yes: ❑ mild ❑ moderate ❑ severe

Amount of flow:

❑ Even throughout

❑ Clots: ❑ No / ❑ Yes: ❑ 1st day ❑ 2nd day ❑ 3rd day ❑ 4th day ❑ Before flow ❑ After flow

❑ Spotting: ❑ No / ❑ Yes: ❑ 1st day ❑ 2nd day ❑ 3rd day ❑ 4th day ❑ Before flow ❑ After flow

❑ Light: ❑ No / ❑ Yes: ❑ 1st day ❑ 2nd day ❑ 3rd day ❑ 4th day ❑ Before flow ❑ After flow

❑ Heavy: ❑ No / ❑ Yes: ❑ 1st day ❑ 2nd day ❑ 3rd day ❑ 4th day ❑ Before flow ❑ After flow

Other symptoms related to menses:

❑ Discharge ❑ PMS ❑ Headache ❑ Nausea ❑ Constipation ❑ Diarrhea

❑ Swollen Breasts ❑ Mood Swings ❑ Increased Appetite ❑ Decreased Appetite ❑ Insomnia

Have you ever been diagnosed with:

❑ Fibroids ❑ Fibrocystic Breasts ❑ Endometriosis ❑ Ovarian Cysts ❑ PID

❑ Polycystic Ovary Syndrome ❑ STD:_____

Fertility Information

# of IVF procedures:_____ # of IUI procedures:_____

Has a physician diagnosed a difficulty with fertility due to: ❑ Female Factor ❑ Male Factor ❑ Unexplained

Informed Consent for Oriental and Chiropractic Medical Treatment

I hereby request and consent to the performance of acupuncture treatments, chiropractic, and other procedures within the scope of the practice of Oriental and chiropractic medicines, for the purposes of demonstration for students only, on me, or on the patient named below, for whom I am legally responsible, by the doctor of Oriental medicine named below and/or other doctors of Oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor 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.

There are some risks to treatment, including but not limited to some bruising of the skin and or/ slight bleeding. If moxibustion or heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are either disposable or are autoclaved according to applicable state legal requirement.

I have had an opportunity to discuss with the doctor named below the nature and purpose of Oriental and chiropractic medicine. I understand that results are not implied nor guaranteed.

I DO NOT EXPECT THE DOCTOR TO BE ABLE TO ANTICIPATE AND EXPLAIN ALL RISKS AND COMPLICATIONS.
I WISH TO RELY ON THE DOCTOR TO EXERCISE JUDGMENT WHICH THE DOCTOR FEELS AT THE TIME IS IN MY BEST INTEREST, BASED UPON THE FACTS THEN KNOWN, DURING THE COURSE OF THE PROCEDURE.

I UNDERSTAND THAT I HAVE THE CHOICE TO ACCEPT OR REJECT THE PROPOSED DIAGNOSTIC PROCEDURE OR TREATMENT, OR ANY PART OF IT, BEFORE OR DURING THE DIAGNOSIS OR TREATMENT.

I understand that the doctor is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (*i.e.* MD) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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'S NAME (print)_____

PATIENT SIGNATURE: **X** DATE: _____

(Or Patient Representative): **X** Relationship to Patient: _____

❑ I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment.

DOCTOR'S SIGNATURE: **X** Date: _____

Consulting Doctor:_____