

**East Lake Acupuncture Clinic**

20425 Yorba Linda Blvd. Yorba Linda, CA 92886

www.eastlake-acupuncture.com

Tel: (714) 779-8800

**PATIENT INTAKE FORM**

**Thank you for choosing East Lake Acupuncture Clinic. This is a confidential questionnaire to help us determine the best treatment plan for you. Please fill in as much information as you can provide. If you have any questions, please don’t hesitate to ask. Thank you.**

**PERSONAL INFORMATION**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age (\_\_\_\_\_\_)

Sex M F Marital Status: S M D W

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under care of a physician? N Y, for what conditions?

Please describe your current health problem(s)

How and when it began

What treatment have you received for the above condition(s)? Surgery Medications

 Physical Therapy Chiropractic Massage Other

Please describe your progress: Worse No Change 0-25% Better 26-50% Better

 51-75% Better 76-100%Better

Have you had acupuncture treatment before? No Yes, Where and when?

 X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_/\_\_\_\_/\_\_\_\_

 Signature of patient or Parent/Guardian if minor MM DD YY

**MEDICAL HISTORY/FAMILY MEDICAL HISTORY**

Please list all past medical conditions & hospitalizations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT HEALTH CONDITION**

Please check all of the following conditions or problems that apply to you.

\_\_Alcohol/Drug Dependence

\_\_Abnormal Menstruation

\_\_Allergies

\_\_Angina

\_\_Arthritis/Rheumatoid Arthritis

\_\_Artificial Joints (list date and joint)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Asthma

\_\_Blood Disorder

\_\_Breast Lumps

\_\_Cancer/Tumor (type and date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Convulsions/Seizures

\_\_Diabetes

\_\_Excessive Thirst

\_\_Fainting or Dizziness

\_\_Fatigue

\_\_Fever

\_\_Frequent Urination

\_\_Headache

\_\_Heart Attack (date\_\_\_\_\_\_\_)

\_\_Heartburn or Indigestion

\_\_High Blood Pressure

\_\_Hospitalizations (date and reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Surgeries (list date and type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Kidney Disease

\_\_Liver Problems

\_\_Osteoporosis

\_\_Pacemaker

\_\_Palpitation/Arrhythmia

\_\_Peptic Ulcer

\_\_Pregnant, #weeks\_\_\_ If pregnant, are you under a medical doctor’s care?\_\_Y/N

\_\_Prostate Problems

\_\_Weight Gain/Loss

\_\_Sinusitis

\_\_Stroke (date\_\_\_\_\_\_\_\_)

\_\_Tobacco Use – type\_\_\_\_\_\_ Frequency \_\_\_\_\_\_/Day

\_\_Thyroid Disease

\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a family member has had any of the following, please check the appropriate condition and explain the relationship:

\_\_Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Heart Disease\_\_\_\_\_\_\_\_\_\_

\_\_Hypertension\_\_\_\_\_\_\_\_\_\_\_

\_\_Lupus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

Describe your current health condition: Excellent Very Good Good Fair Poor

What are your main complaints that brought you in to this office? Please provide a brief history.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other health conditions that are causing you worry or discomfort?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of patient or Parent/Guardian if minor Print Name (First & Last) MM DD YY

**SHOW ME WHERE IT HURTS**

Pain Scale: Please circle

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

My Pain Is: Constant Frequent Intermittent Occasional

I have a: Dull Pain Sharp Pain Electric Pain Numbness Throbbing pain

 Shooting Pain Aching Cold Feeling Hot Feeling

In the past week, how much has your pain interfered with your daily activities? Please circle

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Please circle the areas where you are feeling pain:



 **R L R R L L**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of patient or Parent/Guardian if minor Print Name (First & Last) MM DD YY

**Release of Information**

All information provided herein is true and correct. I will not hold any providers or any staff member of *East Lake Acupuncture Clinic* responsible for any error or omissions that I may have made in the completion of this form. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees and/or beneficiaries and other related persons. I have read and understood this release.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_/\_\_\_\_/\_\_\_\_

 Signature of patient or Parent/Guardian if minor Print Name (First & Last) MM DD YY

**Transferring Session & Refund Policy**

When purchasing our 4 or 10 session packages, I understand that if I choose to give a session to a family member (only) it will cost me **two** sessions. Also, if you decide you would like a refund from the package purchased, then you will be charged **$65.00** for every visit you did use and would be refunded the remaining balance. I have read and understood this policy.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of patient or Parent/Guardian if minor Print Name (First & Last) MM DD YY

**Informed Consent and Disclosure Form**

I hereby request and consent to the performance of acupuncture treatment and other procedures within the acupuncture scope of practice on me (or on the patient below for whom I am legally responsible for) by the acupuncturist 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 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 (oriental massage), Oriental herbal medicine, 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 be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, but that it may haves some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice or Oriental Medicine, although some may be toxic in large dosages. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach aches, vomiting, headaches, 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.

I understand that the provider will explain all known risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment. By voluntarily signing below, I show that I have read the above consent and treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to asks questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of patient or Parent/Guardian if minor Print Name (First & Last) MM DD YY