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.

Date___/___/_______
MM DD YY

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?_____________

____

How did you hear about us?

____

Name: (last)__________________(First)_____________________ Date:____/____/____

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.

__ asthma	__fibromyalgia	__lupus
__ allergies	__frequent urination	__Lyme's disease
__anxiety	__feeling cold	__menstrual disorders
__AIDS/HIV	__feeling hot	__neck pain
__arthritis	__foot pain	__numbness/tingling
__back pain	__gastrointestinal disorder	__night sweats
__blurred vision	__gout	__palpitation (heart)
__breathing difficulties	__glaucoma	__poor appetite
__cancer	__hepatitis	__poor coordination
__carpal tunnel syndrome	__hot flashes	__persistent cough
__chest pain (or tightness)	__headaches	__restlessness
__chronic fatigue	__heart problems	__shoulder pain
__constipation	__hives	__spinal misalignment
__depression	__high blood pressure	__spinal fusion
__diabetes	__irritable bowel syndrome	__skin issues
__diarrhea	__immune deficiency	__sport injury
__difficult concentrating	__itchiness	__sciatica
__digestion issues	__insomnia	__stress
__dizziness/light headedness	__lack of clarity	__tendonitis

__other (please specify)____

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?

____

____

Name: (last)___________________(First)______________________ Date:____/____/____

SHOW ME WHERE IT HURTS

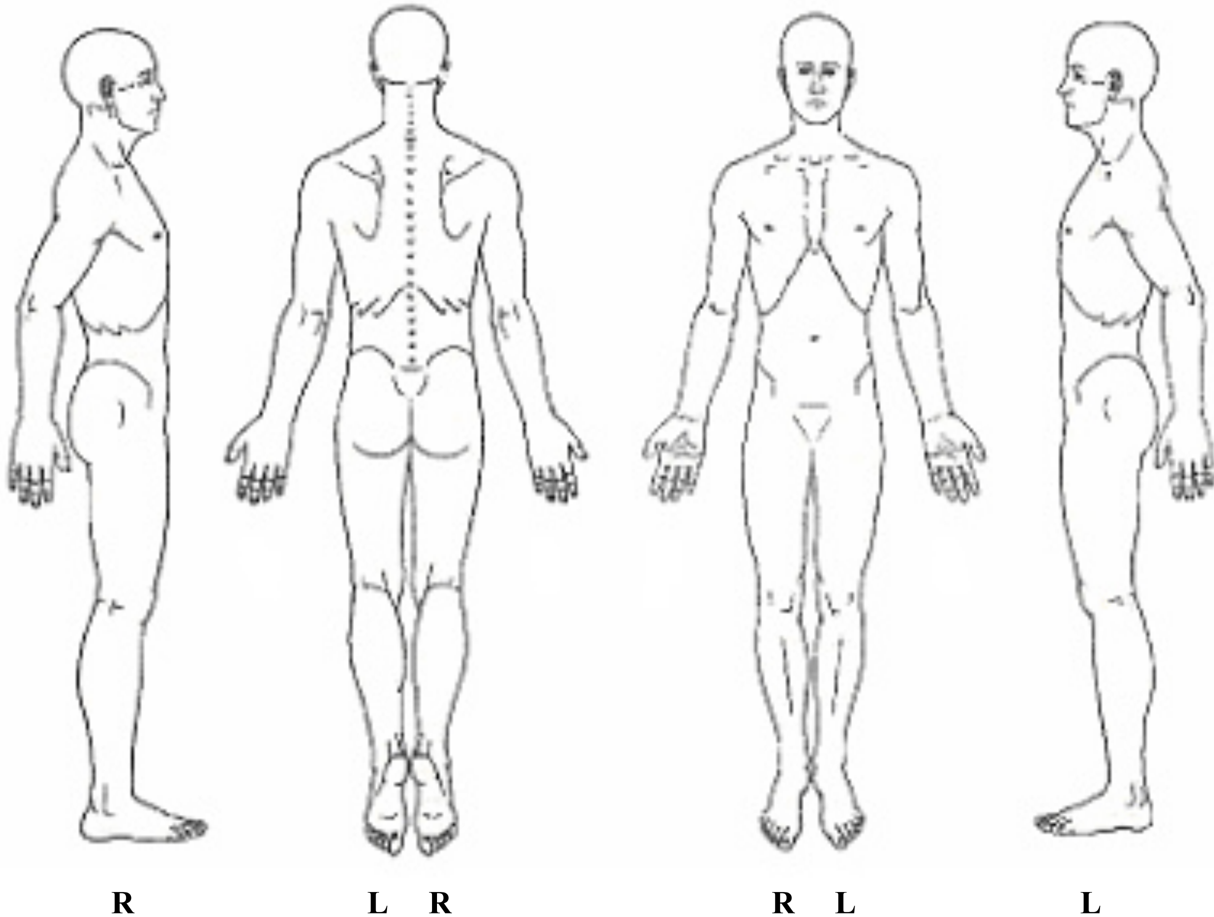
Pain Scale : No Pain Minimal Slight Moderate Severe Pain

0 1 2 3 4 5 6 7 8 9 10

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

Please circle the areas where you are feeling pain:



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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____ Date___/___/_____

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

Transferring Session Policy (4 Session Package Only)

When purchasing our 4 session package, I understand that if I choose to give a session to a family member (only) it will cost me **two** sessions. I have read and understood this policy.

X____ Date___/___/_____

Signature of patient or Parent/Guardian if minor 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____ Date___/___/_____

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