Z. Heart & Sol, LLC

Acupuncture Intake Form

Important: Complete this document as thoroughly as possible. Some of the questions that may follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Date: ____/ ____/ _____ Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Age: _____

DOB: ____/ ____/ _____ Guardian (if under 18): _____

Gender: ☐M ☐F Height: _____'_____" Weight: _____lbs.

How did you hear about our office? _____

Other physicians/therapists seen for this condition:_____

Medications/Supplements (if any vitamins, herbs, mineral, etc.):

_____

_____

Major complaint(s) in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	☐	☐	☐	☐	_____
2.	☐	☐	☐	☐	_____
3.	☐	☐	☐	☐	_____
4.	☐	☐	☐	☐	_____

How do these conditions impair your daily activities? _____

_____

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Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays: _____

Check any you have had in the past:

☐Diabetes	☐Allergies	☐Glaucoma	☐Rheumatic Fever	☐High blood pressure
☐Vein condition	☐Asthma	☐Pneumonia	☐Thyroid disorder	☐Other liver illnesses
☐Tuberculosis	☐Emphysema	☐Jaundice	☐Bleeding tendency	☐Other kidney illnesses
☐Heart Disease	☐Syphilis	☐Measles	☐Multiple Sclerosis	☐Other spleen illnesses
☐Paralysis	☐Cancer	☐CVA (Stroke)	☐Polio	☐Other lung illnesses
☐Gonorrhea	☐Mumps	☐HIV	☐Mononucleosis	☐Other stomach illnesses
☐Hepatitis	☐Migraines	☐High fever	☐Epilepsy	☐Other: _____

Where are you in the birth order? ☐First ☐Last ☐Middle ☐Only

Check the following that have occurred in your blood relatives:

☐Diabetes	☐Cancer	☐Heart Disease	☐High Blood Pressure
☐Allergies	☐Tuberculosis	☐Obesity	☐Bleeding tendency
☐Kidney Disease	☐Alcoholism	☐Nervous Illness	☐Mental Illness
☐Stroke	☐Other:_____		

Patient Profile

Please clearly mark any areas of pain and scars (Please indicate which of the areas are scars):

Is the pain:

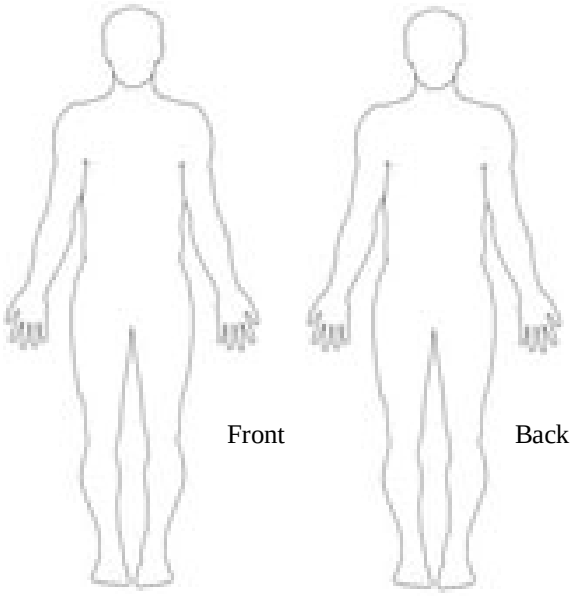
☐Sharp	☐Burning	☐Aching
☐Cramping	☐Dull	☐Moving
☐Fixed	☐Other_____	

Do the following lessen the pain?

☐Pressure	☐Cold	☐Heat
☐Exercise	☐Other _____	

Do the following worsen the pain?

☐Pressure	☐Cold	☐Heat
☐Exercise	☐Other _____	



Front Back

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Please check the following that pertain to you:

Overall Temperature (Kidney function):

- ☐Cold hands
- ☐Sweaty hands
- ☐Hot body temperature (sensation)
- ☐Afternoon flushes
- ☐Heat in the hands, feet and chest
- ☐Thirsty
- ☐Lack of perspiration
- ☐Difficulty keeping eyes open in the daytime
- ☐Cold feet
- ☐Sweaty feet
- ☐Cold body temperature (sensation)
- ☐Night sweats
- ☐Hot flashes any time of the day
- ☐Perspire easily
- ☐Take water to bed

Overall Energy (Lung, Kidney function):

- ☐Shortness of breath
- ☐General weakness
- ☐Low energy
- ☐Difficulty keeping eyes open in the daytime
- ☐Easily catch colds
- ☐Feel worse after exercise

Blood (Liver, Spleen, Heart function):

- ☐Dizziness
- ☐See floating black spots

Heart function:

- ☐Palpitations
- ☐Sores on the tip of the tongue
- ☐Mental confusion
- ☐Frequent dreams
- ☐Drink coffee (# of cups per week: _____)
- ☐Anxiety
- ☐Restlessness
- ☐Chest pain traveling to shoulder
- ☐Wake unrefreshed

Lung function:

- ☐Nasal Discharge (Color: _____)
- ☐Nose Bleeds
- ☐Dry mouth
- ☐Dry nose
- ☐Allergies (To what? _____)
- ☐Sneezing
- ☐Overall achy feeling in the body
- ☐Stiff shoulders
- ☐Difficulty breathing
- ☐Sadness
- ☐Cough
- ☐Sinus Congestion
- ☐Dry throat
- ☐Dry Skin
- ☐Alternating fever and chills
- ☐Headache (Location: _____)
- ☐Stiff neck
- ☐Sore throat
- ☐Smoke cigarettes (# of cigarettes per day: _____)
- ☐Melancholy

Spleen function:

- ☐Low appetite
- ☐Abrupt weight loss
- ☐Abrupt weight gain
- ☐Abdominal bloating
- ☐Abdominal gas
- ☐Gurgling noise in the stomach
- ☐Fatigue after eating
- ☐Easily bruised
- ☐Hemorrhoids
- ☐Pensive
- ☐Over-thinking
- ☐Worry
- ☐Prolapsed organs (previously diagnosed, which organs? _____)

Spleen, Stomach, Large Intestine, Small Intestine function:

- ☐Loose
- ☐Constipated
- ☐Incomplete
- ☐Diarrhea
- ☐Blood in stools
- ☐Mucous in stools
- ☐Undigested food in stools

Dampness trapped in the body:

- ☐General sensation of heaviness in the body
- ☐Mental heaviness
- ☐Mental sluggishness
- ☐Mental fogginess
- ☐Swollen hands
- ☐Swollen feet
- ☐Swollen joints
- ☐Chest congestion
- ☐Nausea
- ☐Snoring

Stomach function:

- ☐Burning sensation after eating
- ☐Large appetite
- ☐Bad breath
- ☐Mouth (canker) sores
- ☐Bleeding, swollen or painful gums
- ☐Heartburn
- ☐Acid regurgitation
- ☐Ulcer (diagnosed)
- ☐Belching
- ☐Hiccoughs
- ☐Stomach pain
- ☐Vomiting

Liver, Gall Bladder function:

- ☐Alternating diarrhea and constipation
- ☐Chest pain
- ☐Tight sensation in the chest
- ☐Bitter taste in the mouth
- ☐Anger easily
- ☐Frustration
- ☐Depression
- ☐Irritability
- ☐Frequently unable to adapt to stress (What causes the stress?_____)
- ☐Skin rashes
- ☐Headache at the top of the head
- ☐Tingling sensation
- ☐Numbness
- ☐Muscle spasms
- ☐Muscle twitching
- ☐Muscle cramping
- ☐Seizures
- ☐Convulsions
- ☐Lump in the throat

Liver, Gall Bladder function (con't):

☐Neck tension
☐Shoulder tension
☐Recreational drugs (which? _____ (How much per week?_____)
☐Drink alcohol
☐Gall stones (history or current)
☐Sexually transmitted disease (Which? _____)
☐Limited Range-of-Motion; Neck
☐Limited Range-of-Motion; Shoulder
☐High-pitched ringing in the ears

Eyes (Liver function):

☐Itchy ☐Bloodshot ☐Hot ☐Dry
☐Watery ☐Gritty ☐Blurry vision ☐Decreased night vision
☐Near-sighted ☐Far-sighted

Kidney, Urinary Bladder function:

☐Frequent cavities
☐Sore knees
☐Cold sensation in the knees
☐Memory problems
☐Low-pitched ringing in the ears
☐Bladder infections
☐Lack of bladder control
☐Easily startled
☐Easily broken bones
☐Weak knees
☐Low back pain
☐Excessive hair loss
☐Kidney stones
☐Wake during the night twice or more to urinate
☐Fear

Urination:

☐Normal color
☐Clear
☐Cloudy
☐Profuse
☐Burning
☐Discharge
☐Painful
☐Frequent
☐Dark yellow
☐Reddish
☐Scanty
☐Strong odor
☐Painful
☐Difficult
☐Urgent

Libido:

☐Low ☐Normal ☐High
☐Other symptoms:

Women only:

Regular menstrual cycle? ☐Y ☐N

Pregnant? ☐Y ☐N

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Number of children: _____ Number of pregnancies: _____

Age of first menstruation: _____ Age of menopause: _____

Average number of days of flow: _____ Average number of days of entire cycle: _____

Vaginal discharge? □Y □N Bleeding between periods? □Y □N

Do you experience any of the following pre-menstrual syndromes?

□Nausea □Headaches
□Anxiety □Other emotions
□Food cravings □Irritability
□Breast swelling □Breast tenderness
□Depression □Water retention
□Vomiting □Migraines
□Dull pain, where? _____
□Sharp pain, where? _____
□Other: _____

Menses: (Please fill out even if you are not currently menstruating on a regular basis):

Color □normal □bright red □pale □brown
□rust □dark □purple □other: _____

Amount of flow □normal □heavy □light

Pain/cramps □dull □sharp □other: _____
location_____

Clots □large □small □black □purple □red
□other:_____

Check only if yes: □ Vomiting □Nausea

Other: _____

Men only:	**Severe**	**Moderate**	**Slight**	**Normal**
Swollen testes				
Testicular pain				
Impotence				
Premature ejaculation				
Feeling of coldness or numbness in exernal genitalia				
Other				

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I, _____, hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturist.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Chinese or Western herbal medicine and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below the nature and purpose of acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases and dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection, and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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. I understand that some herbs may be inappropriate during pregnancy and will consult my prenatal doctor before consuming any. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

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:_____ Patient's Signature:_____Date:_____

Practitioner's Name:_____ Practitioner's Signature: _____Date:_____

ADVICE TO CONSULT A PHYSICIAN

I, _____, affirm that I have been advised by the attending acupuncturist, to consult a physician regarding the condition or conditions for which I am seeking acupuncture treatment. By signing below, I acknowledge receipt of this document.

Patient's Name:_____ Patient's Signature:_____Date:_____

Practitioner's Name:_____ Practitioner's Signature: _____Date:_____