



# ACUPUNCTURE INTAKE

Name: \_\_\_\_\_

Street: \_\_\_\_\_ City, State \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address (for appointment confirmations & Monthly newsletter) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Provider's Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Approx. blood pressure? \_\_\_\_\_ With Meds? \_\_\_\_\_

By whom were you referred? \_\_\_\_\_

What is your chief complaint or reason(s) for this visit? \_\_\_\_\_

When did you first notice symptoms? \_\_\_\_\_

What improves the condition? \_\_\_\_\_

What worsens the condition? \_\_\_\_\_

What treatments have you tried? \_\_\_\_\_

Have you received Acupuncture treatments before? YES NO

Where? \_\_\_\_\_ When? \_\_\_\_\_

By whom? \_\_\_\_\_

Are you willing to take Chinese Herbs if so prescribed by your practitioner? YES NO

**Pursuant to the requirements of Section 6.11, Subsection (d) V. A. C. S., article 4495b, governing the practice of Acupuncture**

I, (patient's name), \_\_\_\_\_, am notifying Patti McCormick, L. Ac., of the following:

YES	NO	NA	I have been evaluated by a physician or dentist for the condition being treated within the six months before this acupuncture treatment was performed.
_____	(initials of patient)		I recognize that I <i>should</i> be evaluated by a physician for the condition being treated by the acupuncturist.

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

## ACUPUNCTURE INTAKE

### PAST MEDICAL HISTORY

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Colitis/Bowel Disease    | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> HIV Positive       | <input type="checkbox"/> Tonsilitis       |
| <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Malaria                  | <input type="checkbox"/> Typhoid Fever      | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Elevated Liver Enzymes   | <input type="checkbox"/> Measles            | <input type="checkbox"/> Rheumatism       |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Mononucleosis            | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Nephritis          | <input type="checkbox"/> Small Pox        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Food,Chem,Drug Poisoning | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Hernia           |
| <input type="checkbox"/> Bladder Disease     | <input type="checkbox"/> Gall Stones              | <input type="checkbox"/> Hepatitis (type?)  | <input type="checkbox"/> Heart Disease    |
| <input type="checkbox"/> Breast Lumps        | <input type="checkbox"/> Neuralgia                | <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Chicken Pox      |
| <input type="checkbox"/> Polio or Meningitis | <input type="checkbox"/> Goiter                   | <input type="checkbox"/> Candida            |   |
| <input type="checkbox"/> Bursitis            | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Cancer _____       |   |

Other: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Significant Traumas (auto accidents, death of loved one): \_\_\_\_\_

Allergies (drugs, chemicals, foods, airborne): \_\_\_\_\_

Medications taken in the last month (include vitamins, over-the-counter drugs, herbs,...): \_\_\_\_\_

### CURRENT MEDICAL INFORMATION (FOR PREVIOUS 3 MONTHS)

#### GENERAL

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fever  | <input type="checkbox"/> Chills             | <input type="checkbox"/> Cravings (what?) |
| <input type="checkbox"/> Insomnia   | <input type="checkbox"/> Excessive dreaming | <input type="checkbox"/> Feel cold often  |
| <input type="checkbox"/> Bleed or bruise easily                             | <input type="checkbox"/> Disturbing dreams  | <input type="checkbox"/> Feel hot often   |
| <input type="checkbox"/> Excessive antibiotic use (episodes per year _____) |   |   |

#### SKIN AND HAIR

- |                                       |                                 |   |
|---------------------------------------|---------------------------------|---|
| <input type="checkbox"/> Rashes       | <input type="checkbox"/> Acne   | <input type="checkbox"/> Hives          |
| <input type="checkbox"/> Itching      | <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent moles   |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Boils  | <input type="checkbox"/> Premature gray |

Other: \_\_\_\_\_

#### HEAD, EYES, EARS, NOSE, AND THROAT

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Spots in front of eyes  | <input type="checkbox"/> Headaches (chronic?) |
| <input type="checkbox"/> Recent change in vision           | <input type="checkbox"/> Night blindness         | <input type="checkbox"/> Migraine             |
| <input type="checkbox"/> Blurry vision                     | <input type="checkbox"/> Eye pain                | <input type="checkbox"/> Grinding teeth       |
| <input type="checkbox"/> Poor hearing                      | <input type="checkbox"/> Dry eyes                | <input type="checkbox"/> Jaw clicks           |
| <input type="checkbox"/> Recurrent sore throats            | <input type="checkbox"/> Red & itchy eyes        | <input type="checkbox"/> Earaches             |
| <input type="checkbox"/> Sinus problems (acute or chronic) | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Facial pain          |
| <input type="checkbox"/> Runny nose                        | <input type="checkbox"/> Sneezing                | <input type="checkbox"/> Nasal congestion     |
| <input type="checkbox"/> Gum problems                      | <input type="checkbox"/> Nose bleeds             |   |

Other: \_\_\_\_\_

## ACUPUNCTURE INTAKE

### GASTROINTESTINAL

- |                                     |                                      |   |                                       |
|-------------------------------------|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Nausea     | <input type="checkbox"/> Vomiting    | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas        | <input type="checkbox"/> Diarrhea    | <input type="checkbox"/> Abdominal cramps     |                                       |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Belching             | <input type="checkbox"/> Indigestion  |
- Other: \_\_\_\_\_

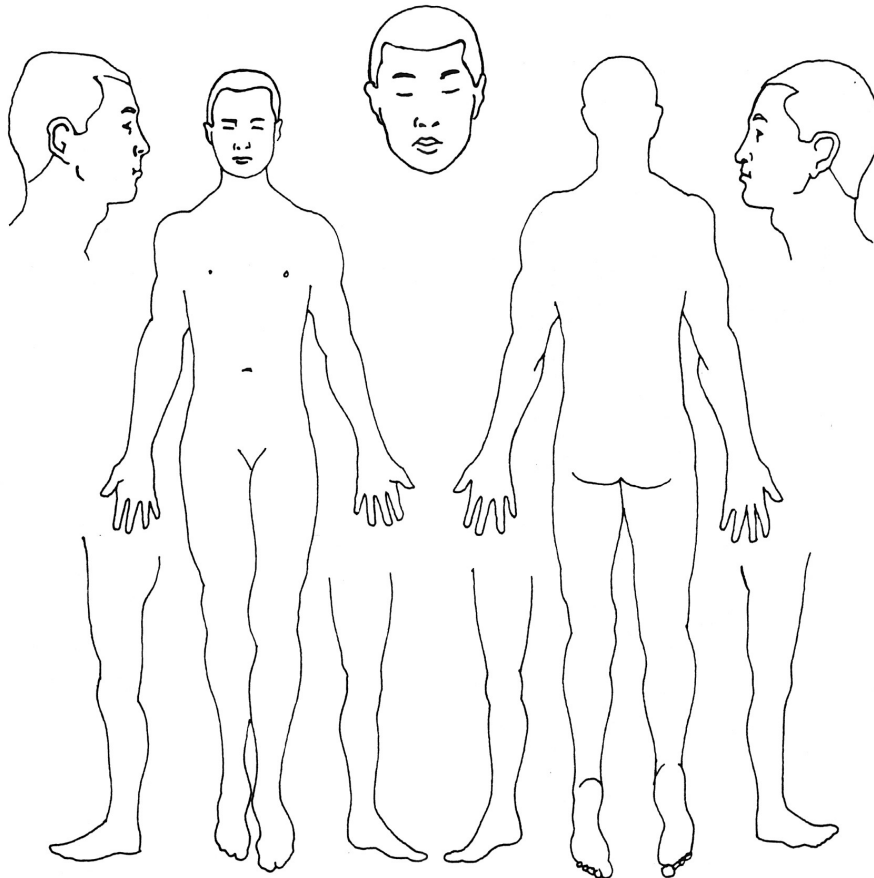
### GENITO-URINARY

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Prostate problems                          | <input type="checkbox"/> Impotence | <input type="checkbox"/> Urinary Tract Infections (chronic or acute) |
| <input type="checkbox"/> Herpes (outbreaks how often?) Other: _____ |                                    |  |

### MUSCULOSKELETAL

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Neck pain                             | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Hip pain        |
| <input type="checkbox"/> Back pain                             | <input type="checkbox"/> Muscle pain     | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Elbow pain      |
| <input type="checkbox"/> Back pain (radiates down back of leg) |  | <input type="checkbox"/> Knee pain       | <input type="checkbox"/> Cortisone shots |
| <input type="checkbox"/> Back pain (radiates down side of leg) |  | <input type="checkbox"/> Foot/ankle pain |  |
- Other: \_\_\_\_\_

### PLEASE MARK PAINFUL OR DISTRESSED AREAS



## ACUPUNCTURE INTAKE

### CARDIOVASCULAR

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain                      |
| <input type="checkbox"/> Irregular heartbeat    | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Palpitations                    |
| <input type="checkbox"/> Cold hands and/or feet | <input type="checkbox"/> Swelling of hands  | <input type="checkbox"/> Fainting                        |
| <input type="checkbox"/> Blood clots            | <input type="checkbox"/> Swelling of feet   | <input type="checkbox"/> Diagnosed mitral valve prolapse |

Other: \_\_\_\_\_

### RESPIRATORY

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cough (dry or productive)            | <input type="checkbox"/> Coughing blood        | <input type="checkbox"/> Production of phlegm (color? _____) |
| <input type="checkbox"/> Bronchitis (acute or chronic?)       | <input type="checkbox"/> Pain with deep breath | <input type="checkbox"/> Pneumonia                           |
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Asthma                |  |

Other: \_\_\_\_\_

### NEUROPSYCHOLOGICAL

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Cry often            | <input type="checkbox"/> Anxiety         |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Stress          |
| <input type="checkbox"/> Concussion        | <input type="checkbox"/> Depression           | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Bad temper        | <input type="checkbox"/> Considered suicide   | <input type="checkbox"/> Poor memory     |
| <input type="checkbox"/> Worry             | <input type="checkbox"/> In therapy now       | <input type="checkbox"/> Mania           |
| <input type="checkbox"/> Physically abused | <input type="checkbox"/> Emotionally abused   | <input type="checkbox"/> Sexually abused |

Hospitalized for emotional issues: \_\_\_\_\_

Do you feel you get adequate affection in your life? \_\_\_\_\_

Other: \_\_\_\_\_

### REPRODUCTIVE & GYNECOLOGICAL (Women Only)

- |   |   |   |
|---|---|---|
| _____ # of Pregnancies                                  | _____ # of Births                                 | _____ # of Miscarriages                                   |
| <input type="checkbox"/> Long periods (7 days or more)  | <input type="checkbox"/> Irregular periods        | <input type="checkbox"/> Vaginal discharge (color & odor) |
| <input type="checkbox"/> Short periods (3 days or less) | <input type="checkbox"/> Clotting                 | <input type="checkbox"/> Yeast infections                 |
| <input type="checkbox"/> Painful periods                | <input type="checkbox"/> PMS - breast distension  | <input type="checkbox"/> Menopausal symptoms              |
| <input type="checkbox"/> Painful ovulation              | <input type="checkbox"/> PMS - emotional symptoms | <input type="checkbox"/> Birth control (what type?)       |

Please let your practitioner know if there is any chance you may be pregnant today.  
Some acupuncture points and herbs are contraindicated during pregnancy.

Other: \_\_\_\_\_

### COMMENTS

Please tell me of any other issues you would like to discuss: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ACUPUNCTURE INTAKE

### **Cancellation Policy**

At Sana Vida, we all believe in respecting time. We will always do our best to prevent you from waiting before your appointments and/or having to change your appointments. We ask that, in return, you also respect our time. Please kindly give 24 hour notice if you need to change your appointment so another client can utilize that time slot. We reserve the right to charge 50% of service fee or \$40 (whichever is less) for same day cancellations and missed appointments ("no shows".)

### **Informed Consent**

Each person is different in their response to acupuncture. During your course of acupuncture treatments, it is possible that your symptoms may get worse, either later that day or evening, or even the next day. This does not happen with every client. However, we do feel it is necessary to inform you of the possibility so that you will not be surprised or concerned if and when it occurs. Increased sensitivity can happen after the first, second, or any subsequent treatment. If this sensitivity happens, it usually occurs only once and lasts for a few hours up to the full duration of that day. A response of hypersensitivity is actually a good sign that your system is responding to the acupuncture stimulation.

We feel it is important to inform you of the possible side effects of acupuncture:

1. There is a slight chance that a bruise may appear at the site of the needle insertion. This is due to lightly brushing a blood vessel. The bruise should dissipate within a few days. Rub the area to keep the blood circulating. This may occur at some time during your course of treatments.
2. Slight swelling may occur around the insertion site. The swelling will usually dissipate within 2 to 24 hours. This is just a skin reaction and happens very rarely.
3. Slight redness may appear around the site of insertion. This is usually due to an increase of blood circulation around the needle. This is fairly common and disappears after a couple minutes or hours.
4. If the needle brushes the sheath of a nerve, the area will be sore during and after that treatment for several days. This occurs rarely.
5. You may experience some light-headedness or dizziness after a treatment. This usually lasts only a few minutes. There is no hurry for you to leave. If you need to sit for a while, please feel free to do so in the lobby.
6. You may be slightly tired after a treatment, this is due to the deep relaxation state that is created. We ask that you take your time in getting up off the treatment table.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

## ACUPUNCTURE INTAKE

### CLIENT COPY

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Your good health and welfare are my prime objective and concern.



Patti McCormick, L. Ac.