Lexington Acupuncture Patient Intake

Please take the time to fill out the following information completely and honestly.

~ The information in this packet is kept completely confidential between you and your Doctor except with your explicit permission, or as required by law~

CONTACT INFORMATION			Today's Date:	
Name:			Date of Birth:	
Mailing Address:			Social Security Number	
			Email (Optional):	
			Home Phone:	
City:	State:	Zip:	Cell Phone:	
			Work Phone:	

Occupation: Employer/School:

Are you Married / Single? (circle one)

Emergency Contact Name: Phone: Relationship:

Do You Have Health Insurance? With what company?

Are you the primary insured party on this plan? If not, who is? D.O.B:

How did you hear about us?

Have you ever had acupuncture before? When? Did it help you?

WOMEN: Is there any chance you could be pregnant? If so, how far along are you?

REASON FOR VISIT

Briefly describe your main concern that brings you to this office today:

When did this condition begin?

What makes it better?

What makes it worse?

Have you been given a diagnosis for this condition? What was the diagnosis?

MEDICAL HISTORY

Check all that apply

	Allergies
	Headaches / Migraines
	Arthritis
	High Blood Pressure
	Low Blood Pressure
	Heart Disease
	Blood Clotting Disorder
	Hyper-Thyroid
	Hypo-Thyroid
	Epilepsy
	Cancer
	Diabetes
	Autoimmune Disease
	Venereal Disease
	HIV
	AIDS
	Hepatitis B
	Hepatitis C
	Chemical addiction
	Depression
	Bi-polar

Fill in the following information

Medications/Vitamins/Supplements/Herbs

Please indicate dosages

Major surgeries or hospitalizations

List date and reason for surgery

Falls, broken bones, auto accidents - List dates

FAMILY HEALTH HISTORY

Please check if any of your family members have or have had any of the following

___**Cancer**	Relationship_____
___**Diabetes**	Relationship_____
___**High Blood Pressure**	Relationship_____
___**Low Blood Pressure**	Relationship_____
___**Heart Disease**	Relationship_____
___**Seizures**	Relationship_____
___**Depression**	Relationship_____
___**Hyper-Thyroid**	Relationship_____
___**Hypo-Thyroid**	Relationship_____

Notes:

Please list your daily intake or usage of any of the following items:

Tobacco: **Coffee:** **Alcohol:** **Sugar:** **Water:**

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_____

Systems Review - Please note any issues you have with any of the following systems and/or functions

Digestion

Diet/Nutrition

Elimination

Bowel movements

Urination

Ears, Eyes, Nose and Throat, Head

Sleep

Reproductive System

Lifestyle / Exercise

Energy level

Emotions

Body Temp. and Sweating

Notes:

SYMPTOM SURVEY

The following is a list of symptoms that you may or may not experience. Please indicate as follows:
leave blank if never experience, check mark (✔) if sometimes experience, plus sign (+) if always experience

__lack of appetite
__excessive appetite
__loose stool or diarrhea
__constipation
__difficulty digesting oily foods
__hemorrhoids
__vomiting
__abdominal pain
__digestive problems
__colitis or diverticulitis
__indigestion
__belching, burping
__recent use of antibiotics
__heartburn/reflux
__feeling retention of food in the stomach
__tendency to become obsessive or compulsive

__insomnia, difficulty sleeping
__heart palpitations
__cold hands and feet
__nightmares
__mentally restless
__laughing for no apparent reason
__angina pains
__anxiety attacks
__manic episodes
__poor memory
__difficulty concentrating
__frequent crying
__dry eyes
__dry hair
__dry skin
__dry mouth

__low back pain
__knee problems
__hearing impairment
__ear ringing
__kidney stones
__decreased sex drive
__increased sex drive
__hair loss
__urinary problems
__fearful
__pain or coldness in the genital area

__fatigue
__edema
__blood in stool
__black tarry stool
__easily bruised
__difficult to stop bleeding
__dizziness
__tendency to faint easily
__high cholesterol levels
__sudden weight loss
__sadness or grief
__thirsty
__prefer hot drinks
__prefer cold drinks
__thyroid disorders
__high blood pressure
__tremors
__chest pain
__sciatic pain

__cough
__shortness of breath
__decreased sense of smell
__nasal problems
__asthma
__allergies
__hay fever
__feelings of claustrophobia
__bronchitis
__tendency to catch colds easily
__intolerance to weather changes
__headaches

__eye problems
__jaundice
__gall stones
__light colored stools
__soft or brittle nails
__easily angered or agitated
__difficulty in making plans or making decisions
__spasms or twitching of muscles
__irritability
__breast lumps
__depression
__PMS

MUSCULOSKELETAL

Pain or numbness in any of the following areas
- for pain, please rate levels using a scale from 0-10, 0 is no pain and 10 is the worst.

___neck
___shoulders
___arms/elbows
___wrist/hands
___knees
___feet
___spinal stenosis
___scoliosis

___leg or calf cramping
___muscle weakness
___muscle spasms
___rheumatoid arthritis
___bursitis
___thighs
___legs
___calves

___poor posture
___sciatica
___low back pain
___swollen joints
___numbness in toes
___numbness in fingers
___degenerative joint disorder
___degenerative disc

What relieves your pain/condition?_____
Heat_____Cold_____Damp_____Weather_____Wind_____Medications_____Pressure____
What aggravates your pain/condition?_____
Heat_____Cold_____Damp_____Weather_____Wind_____Medications_____Pressure____

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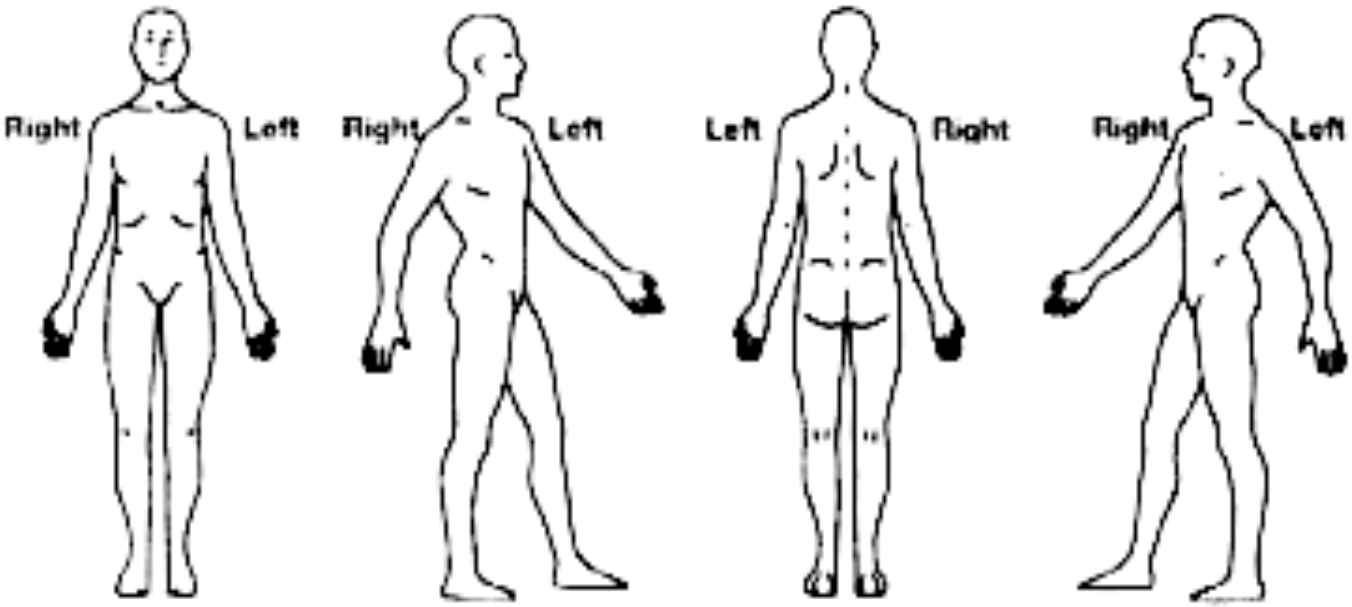
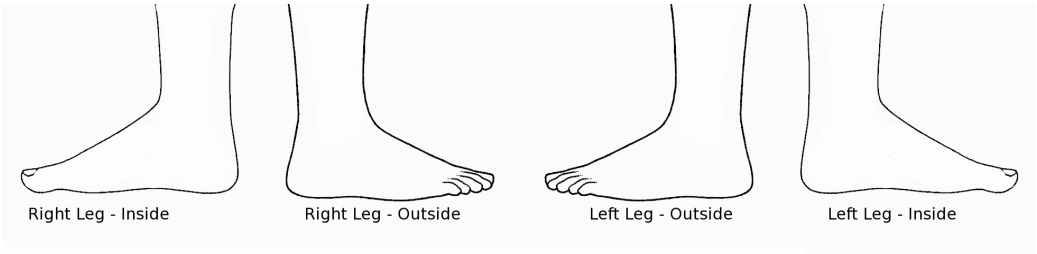
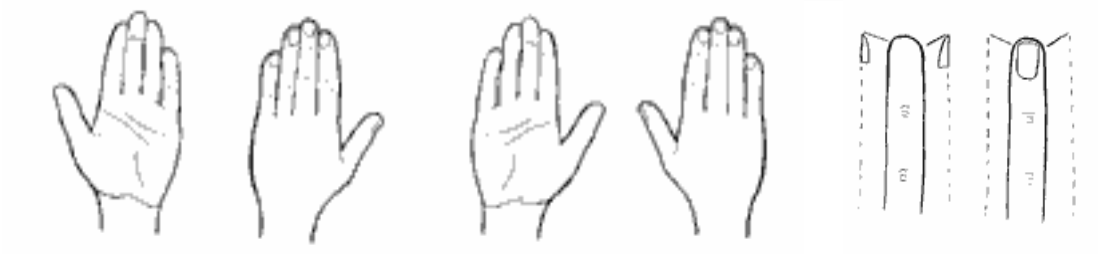
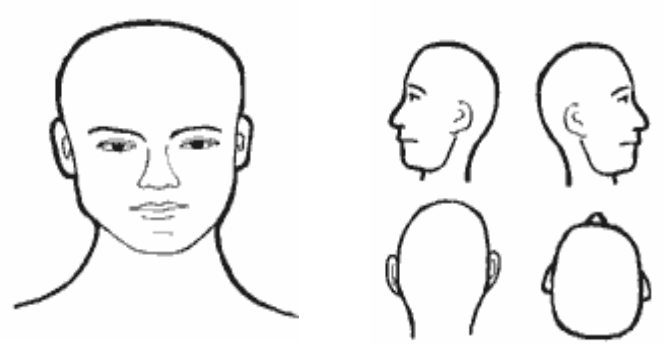
PAIN PICTURE









Please mark your area(s) of pain/discomfort in the appropriate picture(s).

Use the 1-10 pain scale to mark each area of pain

Use the following key to indicate the quality of the pain or the type of discomfort.

Key:

XXX = Sharp pain
AAA = Aching
NNN = Numbness/ tingling
>>> = Radiating pain
BBB = Burning
//// = Tension

Patient's Signature
Doctor's Signature

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named 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 listed 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, Tiu-Na (Chinese massage), Chinese herbal medicine, and 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 unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have 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. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. 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 effect and risks may occur. 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, 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 do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

PRINT PATIENT'S NAME: _____

PATIENT SIGNATURE: **X** _____ (Date) _____

(Or Patient Representative) Indicate relationship if signing for patient _____

OFFICE SIGNATURE: **X** _____ (Date) _____

Joseph Byron L.Ac. Dipl. O.M