



### Acupuncture Intake Form

**This information is confidential**

Date: \_\_\_\_\_

Name: _____	Age: _____ Sex: M / F
Address: _____	Birth Date: _____
_____	Occupation: _____
City: _____ State: _____	Zip Code: _____
Day Time Phone: _____	Evening Phone: _____
Referred by: _____	Physician: _____
_____	Physician Phone # _____
Have you ever had acupuncture? Y / N	_____
Do you bruise easily? Y / N	Blood Type: _____
What is your chief complaint? _____	
_____ How long? _____	
What other treatments have you tried? _____	
_____	
What Medications are you taking?	For what conditions?
_____	_____
_____	_____
_____	_____

### Medical History (Check all that apply)

<input type="checkbox"/> Aids/HIV	<input type="checkbox"/> Alcoholism/Substance Abuse
<input type="checkbox"/> Allergies	<input type="checkbox"/> Hepatitis A / B / C
<input type="checkbox"/> Allergies to Cosmetics	<input type="checkbox"/> Herpes
<input type="checkbox"/> Allergy to Latex	<input type="checkbox"/> Lyme Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Birth Trauma	<input type="checkbox"/> Polio
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Seizures	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Lymph nodes removed	<input type="checkbox"/> Varicose Vaines
Other: _____	

**Injuries, Surgeries, Major illnesses:** \_\_\_\_\_

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Diet: (24 Hour Intake)

Food Cravings? \_\_\_\_\_

Food Intolerances? \_\_\_\_\_

How many glasses do you drink each day of the following?

Water \_\_\_\_\_ Soda \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Alcohol \_\_\_\_\_

How much do you consume of the following?

Meat \_\_\_\_\_ Sweets \_\_\_\_\_ Dairy \_\_\_\_\_ Other \_\_\_\_\_

Do you perspire during the day? \_\_\_\_\_

Do you perspire at night? \_\_\_\_\_

Are you always thirsty? Yes / No

Do you prefer \_\_\_\_\_ hot or \_\_\_\_\_ cold drinks?

Taste preferences on a scale of 1 to 5, 1 being most liked to 5 disliked:

Salty \_\_\_\_\_ Sour \_\_\_\_\_ Bitter \_\_\_\_\_ Sweet \_\_\_\_\_ Spicy \_\_\_\_\_

#### Gastrointestinal:

Do you have currently or have you had a major incidence in the past?

Belching \_\_\_\_\_ Nausea \_\_\_\_\_ Vomiting \_\_\_\_\_ Ulcers \_\_\_\_\_ Bloating \_\_\_\_\_

Indigestion \_\_\_\_\_ Hernia \_\_\_\_\_ Hemorrhoids \_\_\_\_\_ Acid Reflux \_\_\_\_\_

Bowel movements: How often? \_\_\_\_\_ day/week

Irregularity \_\_\_\_\_ Constipation \_\_\_\_\_ Diarrhea \_\_\_\_\_ Gas \_\_\_\_\_ Burning \_\_\_\_\_

#### Exercise and Energy:

What kind of exercise do you engage in? \_\_\_\_\_ How often? \_\_\_\_\_

How is your general energy level? \_\_\_\_\_

Are you sedentary or active? \_\_\_\_\_

#### Emotions and Sleep:

Panic attacks \_\_\_\_\_ Depression \_\_\_\_\_ Anxiety \_\_\_\_\_ Nervous \_\_\_\_\_

Fear \_\_\_\_\_ Poor Memory \_\_\_\_\_ Difficulty concentrating \_\_\_\_\_

Do you take antidepressants? \_\_\_\_\_ What kind? \_\_\_\_\_

Do you take sleeping pills? \_\_\_\_\_ What kind? \_\_\_\_\_

Difficulty falling asleep \_\_\_\_\_ Restless \_\_\_\_\_ Disturbed Sleep \_\_\_\_\_

Dreams \_\_\_\_\_ Waking up at \_\_\_\_\_ am/pm

#### Urination:

How often? \_\_\_\_\_ times per day Color \_\_\_\_\_ Bladder Infections \_\_\_\_\_

Frequent Urination \_\_\_\_\_ Incontinence \_\_\_\_\_ Burning \_\_\_\_\_

#### Gynecology:

Are you menstruating still? \_\_\_\_\_ Irregular menses \_\_\_\_\_ Heavy Flow \_\_\_\_\_

Light Flow \_\_\_\_\_ No Flow \_\_\_\_\_ Blood Clots \_\_\_\_\_ PMS \_\_\_\_\_

Painful Periods \_\_\_\_\_ Uterine Fibroids \_\_\_\_\_ Cystic Breasts \_\_\_\_\_

Are you perimenopausal? \_\_\_\_\_ Symptoms \_\_\_\_\_

Are you menopausal? \_\_\_\_\_ Symptoms \_\_\_\_\_



**Sexual Health:**

How is your sex life? \_\_\_\_\_  
How is your libido? \_\_\_\_\_  
Dryness \_\_\_\_\_ Impotence \_\_\_\_\_ Erectile dysfunction \_\_\_\_\_

**Respiratory, ENT and Head:**

Do you smoke? Y / N \_\_\_\_\_ times /day for \_\_\_\_\_ years  
Frequent colds \_\_\_\_\_ Asthma \_\_\_\_\_ Dizziness \_\_\_\_\_ Cold Sores \_\_\_\_\_  
Bleeding Gums \_\_\_\_\_ Dry Mouth \_\_\_\_\_ Ear Pain \_\_\_\_\_ Migraine \_\_\_\_\_  
Ringing in Ears \_\_\_\_\_ Clogged/Popping \_\_\_\_\_ Frequent Headache \_\_\_\_\_  
Sinusitis \_\_\_\_\_ Post Nasal Drip \_\_\_\_\_

**Cardiovascular:**

Palpitations \_\_\_\_\_ Varicose Veins \_\_\_\_\_ Spider Veins \_\_\_\_\_  
Cold Hands/Feet \_\_\_\_\_ Poor Circulation \_\_\_\_\_  
Irregular Heart Beat \_\_\_\_\_

**Skin and Hair:**

Dry Skin \_\_\_\_\_ Skin Rashes \_\_\_\_\_ Itching \_\_\_\_\_ Acne \_\_\_\_\_  
Eczema \_\_\_\_\_ Hives \_\_\_\_\_ Hair Loss \_\_\_\_\_  
Hirsutism (excess body hair) : \_\_\_\_\_

Do you have any additional health conditions?

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## Consent for Acupuncture Procedure or Treatment

1. I hereby authorize Julia Pinkham-Gonzalez to perform the following: acupuncture. I have received the following informed consent for acupuncture sheet:

### Informed Consent for Acupuncture

2. I recognize that during the course of acupuncture, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above acupuncturist to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. It has been explained to me in a way that I understand:
  - a. The above treatment or exposure to be undertaken
  - b. There may be alternative procedures or methods of treatment
  - c. There are risks to the procedure or treatment proposed

**I consent to the treatment or procedure and the above listed items. I am satisfied with the explanation.**

\_\_\_\_\_  
Patient or Authorized Guardian Signature

\_\_\_\_\_  
Practitioner

\_\_\_\_\_  
Date



## INFORMED CONSENT FOR ACUPUNCTURE

An acupuncture treatment involves the insertion of acupuncture needles into the body. In Oriental medicine the meridian pathways of Qi flow throughout the entire body from the soles of the feet up to the face and head; consequently an acupuncture treatment addresses the entire body constitutionally.

An acupuncture treatment involves the patient in an organic, gradual process that is customized for each individual. This treatment incorporates the entire body and constitutional issues of health.

Every procedure involves a certain amount of risk and it is important that you understand the risks involved with an acupuncture treatment. Although the majority of patients do not experience the following complications, you should make sure you understand the risks, potential complications, and consequences of acupuncture.

**Bleeding:** It is possible, though very unusual that you may have bleeding. Should post-acupuncture bleeding occur, it will usually only consist of a few drops. Accumulations of blood under the skin may cause a bruise or hematoma, which will resolve itself.

**Infection:** It is very unusual after acupuncture. Should an infection occur, additional treatment, including antibiotics, may be necessary.

**Damage to Deeper Structures:** Rarely are deeper structures such as blood vessels and muscles damaged during the course of an acupuncture treatment. If this does occur, the injury may be temporary or permanent.

**Bruising:** There is a possibility of bruising, puffiness, blood, tingling, itching, warmth, pain or other symptoms at the site of the needle.

**Nerve Injury:** Injuries to the motor or sensory nerves rarely result from acupuncture treatments. Nerve injuries may cause temporary or permanent loss of movements and feeling. Such injuries may improve over time. Injury to sensory nerves may cause temporary or more rarely permanent numbness. Painful nerve scarring is very rare.



**INFORMED CONSENT FOR ACUPUNCTURE**  
(Continuation)

**Needle Shock:** This is a rare complication of acupuncture. A cardio-vascular collapse, sudden drop of blood pressure with fainting.

**Unsatisfactory Result:** There is a possibility of a poor result from acupuncture, and you may be disappointed with the results.

**Allergic Reactions:** In rare cases, local allergies to topical preparations have been reported. Systemic reactions which are more serious may occur to herbs used. Allergic reactions may require additional treatment.

**Delayed Healing:** Delayed healing or disruption is a rare complication experienced by patients after the treatment. There is a greater risk for smokers, who frequently have dry, sagging skin, which does not heal as readily as that of non-smokers.

**Disclaimer:** Informed-Consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment. The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent should not be considered all-inclusive in define other methods of care and risks encountered. Standards if acupuncture are determined on the basis of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of you questions answered before signing the consent on the next page.