Date:_____ Name:_____

Street Address: _____

City:_____ State:_____ Zip:_____

Home phone: Work phone: Cell:

**** Please mark preferred contact number for reminder calls with a star ****

Email: _____

Date of Birth:_____ Place of Birth:_____Age:_____

Employer Name: _____

In emergency, please notify:_____Phone:_____

How did you hear about our office? _____

Have you been treated by acupuncture before? yes _____ no_____

Do you have an aversion to any Essential Oils? (Please list)_____

Reason #1 for contacting our office:_____

_____

Date of injury:_____If not an injury when did the problem begin?_____

Please describe your symptoms and what makes them better or worse:_____

_____

_____

_____

Has a medical diagnosis been given for this problem?

_____

Previous treatments you have tried and the results:_____

_____

_____

_____

Reason #2 for contacting our office:_____
_____

Date of injury:_____If not an injury when did the problem begin?_____

Please describe your symptoms and what makes them better or worse:_____
_____
_____
_____
_____

Has a medical diagnosis been given for this problem_____

Previous treatments you have tried and the results:_____
_____
_____
_____

Please download and fill out a **Functional Rating Index** for each Condition listed above.

Last Doctor's appointment (date & reason for visit): _____
_____

Please circle the following that apply to you:

| | | | |
|---|---|---|---|
| Pregnant | Bleeding Disorder | Pacemaker | Hepatitis |
| Seizures | | | |
| HIV | High Blood Pressure | Surgical Mesh | Chemo/Radiation |

Please describe any allergies and reactions (drugs, chemicals, foods, or environmental):
_____
_____
_____

Medication/Vitamins/Supplements/Herbs: Reason for taking it:
(Use reverse side if you need more room)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

What is your history of major Illnesses/Traumas:_____
_____
_____

Surgeries:_____
_____
_____

Family Medical History (stroke, heart disease, high blood pressure, cancer, skin disease, mental disorders, seizures, asthma, substance abuse, allergies, diabetes, etc.):
Father:_____
Mother:_____
Siblings:_____
Grandparents:_____
_____

Are you on a restricted diet? Yes No Please describe:_____
_____
_____
_____
_____

Please circle the appropriate number to describe the amounts consumed each day:

| | 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| | none ---------- | | | | | heavy |
| Wheat products (bread, pasta, pastries, etc)…… | 0 | 1 | 2 | 3 | 4 | 5 |
| Grains & legumes…… | 0 | 1 | 2 | 3 | 4 | 5 |
| Dairy products (milk, cheese, butter)…… | 0 | 1 | 2 | 3 | 4 | 5 |
| Seafood (fish & shellfish)…… | 0 | 1 | 2 | 3 | 4 | 5 |
| Animal products (meats, poultry, eggs…..……. | 0 | 1 | 2 | 3 | 4 | 5 |
| Cooked vegetables……..…..0 | | 1 | 2 | 3 | 4 | 5 |
| Raw vegetables……..…0 | | 1 | 2 | 3 | 4 | 5 |
| Water…….0 | | 1 | 2 | 3 | 4 | 5 |
| Sugar…….0 | | 1 | 2 | 3 | 4 | 5 |
| Salt…….0 | | 1 | 2 | 3 | 4 | 5 |
| Processed foods……...0 | | 1 | 2 | 3 | 4 | 5 |

Please describe your habits by filling in the amount and frequency (daily, weekly, monthly):
Cigarettes:_____per_____ Marijuana_____per_____ Alcohol_____per_____
Tea_____per_____ Coffee_____per_____ Soft Drinks_____per_____

What is your work and do you enjoy it?
_____
If not working, what are your main activities?
_____
What do you consider your current stress level to be on a scale of 1-10?
_____
What are the major stress factors in your life?
_____
What do you do to relieve stress or relax?
_____
How much time a day do you watch TV/movies?_____Spend on the computer?_____

Do you have a regular exercise program? Yes No Please describe:_____
_____
What time do you fall asleep? _____Wake?_____Number of hours a night?____
How long does it take you to fall asleep? _____Do you wake feeling rested_____
Do you wake during the night? _____ # of times:_____
Reason:_____
Do you nap or rest during the day? _____ If so for how long? _____
Please rate your general energy level on a scale of 1-10 (one being the lowest):_____
What time of day is it the highest? _____ Lowest?_____

**Please circle any current concerns.**

**General:**

| | | |
|---|---|---|
| Poor appetite | Fevers | Sweat easily |
| Localized weakness | Bleed or bruise easily | Peculiar tastes or smells |
| Sudden energy drop | Weight gain | Weight loss |
| Poor sleeping | Chills | Tremors |
| Poor balance | Fatigue | Night sweats |
| Strong thirst (for hot or cold) | | Thirst, but no desire to drink |
| Cravings, for what: _____ | | Change in appetite |

**Skin and Hair:**

| | | |
|---|---|---|
| Rashes | Itching | Dandruff |
| Change in hair or skin | Ulcerations | Eczema |
| Loss of hair | Hives | Pimples |
| Recent moles | Other, please specify: _____ | |

**Head, eyes, ears, nose and throat:**

| | | |
|---|---|---|
| Dizziness | Glasses | Poor vision |
| Cataracts | Ringing in the ears | Sinus problems |
| Teeth grinding | Teeth problems | Eyes strain |
| Night blindness | Blurry vision | Poor hearing |
| Nose bleeds | Facial pain | Jaw clicks, aches |
| Migraine | Eye pain | Sores on lips or inside mouth |
| Earaches | Spots in front of the eyes | Recurrent sore throats |

Headaches, where on head and how often: _____

---

**Cardiovascular:**

| | | |
|---|---|---|
| High blood pressure | Irregular heartbeat | Cold hands and feet |
| Blood clots | Low blood pressure | Feet feel Hot to you |
| Swelling of hands | Phlebitis | Chest pain |
| Fainting | Swelling of feet | Difficulty breathing |
| Dizziness | | |

Other heart or blood vessel problems: _____

**Respiratory:**

| | | |
|---|---|---|
| Cough | Bronchitis | Coughing blood |
| Asthma | Pain on breathing | Pneumonia |
| Sleep Apnea | Allergies | Rhinitis |
| Difficulty breathing lying down | | Tight chest |

Shortness of Breath (on exertion; walking, climbing stairs, exercising, etc.)

Coughing or blowing nose w/ phlegm: what color? _____

Other lung or breathing problems: _____

**Gastrointestinal:**

| | | |
|---|---|---|
| Nausea | Constipation | Diarrhea |
| Black stools | Bad breath | Abdominal pain/cramps |
| Gas | Chronic laxative use | Vomiting |
| Blood in stools | Rectal pain | Belching |
| Indigestion | Hemorrhoids | |

Other stomach or intestinal problems: _____

**Genito-Urinary:**

| | | |
|---|---|---|
| Pain on urination | Urgency to urinate | Decrease in flow |
| Unable to hold urine | Difficulty urinating | Kidney stones |
| Blood in urine | Sores on genitals | |

**Musculoskeletal:**

| | | |
|---|---|---|
| Neck pain | Back pain | Hand/wrist pain |
| Muscle pain | Muscle weakness | Shoulder pain |
| Knee pain | Foot/ankle pain | Hip pain |

Other: _____

**Neuropsychological:**

| | | |
|---|---|---|
| Seizures | Areas of numbness | Concussion |
| Bad temper | Dizziness | Lack of concentration |
| Depression | Loss of balance | Easily susceptible to stress |
| Poor memory | Anxiety | |

**For women only:**

| | |
|---|---|
| Scanty Menses | Took Birth Control Pills |
| Heavy Menses | Taking Birth Control Pills |
| Vaginal Discharge | Mood Swings |
| Irregular Menses | Breast Pain |
| No Menses | Breast Lumps |
| Uterine Fibroids | Breast Tenderness before menses |
| Uterine Hemorrhage | Infertility |
| PMS | Habitual Miscarriage |

Age when started menses: _____ Age when started menopause: _____

Pregnancies: _____ Age: _____

Miscarriages: _____ Age: _____

Abortions: _____ Age: _____

**For men only:**

| | |
|---|---|
| Decreased sex drive | Impotency |
| Low sperm count | Exhaustion after sex |
| Difficult urination | Nighttime urination |
| Scanty ejaculation | Premature ejaculation |
| Loss of force when urinating | Dribbling after urination |

Please tell me about any other conditions that you would like to address:_____
_____
_____
_____

**Privacy Policy**

As mandated by Federal and State legal requirements, your health information must be protected. As part of these regulations, we are required to ensure that you are aware of out privacy practices.

Your health information may be shared between providers within Elisha's Family Acupuncture. Your health information will be released to another healthcare provider only if you have requested it in writing. It may be used and disclosed to obtain payment for services Elisha's Family Acupuncture has provided to you. We also will use your information to assist you with appointment reminders.

**Informed Consent for Treatment**

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, dizziness and fainting. Bruising is a common side effect of cupping, and burning and/or scarring are potential risks of moxibustion.

I understand that some herbs may interact with prescription drugs, over-the-counter medications, or supplements, and as such I will notify Elisha's Family Acupuncture if I am taking any medication or supplements concurrently with Chinese Herbs. I understand that some herbs and Essential Oils may be inappropriate during pregnancy. I will notify Elisha's Family Acupuncture if I am or become pregnant. Patients with bleeding disorders, pace makers, or surgical mesh should inform us prior to any treatment.

I do not expect Elisha's Family Acupuncture to be able to anticipate and explain all possible risks and complications of treatment. I understand that the results are not guaranteed. I understand that Elisha's Family Acupuncture is not providing Western (Allopathic) medical care, and that I should look to my Primary Care Provider (MD, ND, or DO) for those services and for routine check-ups.

**I understand the acupuncture treatments are my financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been**

**made. I will provide Elisha's Family Acupuncture with at least 24 hours notice if I need to reschedule or cancel an appointment and I understand that I will be charged a fee for any appointment cancelled or changed with less than 24 hours notice. I also understand that my insurance will not cover the fee for missed appointments. Elisha's Family Acupuncture bills insurance on your behalf but it is not a guarantee of payment. I understand that I am financially responsible for all outstanding appointment fees that are not covered by health insurance.**

Signature of Patient or Guardian _____ Date _____