Eastern Channel Acupuncture

CLIENT INTAKE FORM

PO Box 6092 315 Seward St, Suite C Sitka, AK 99835 907-623-0640

PATIENT INFORMATION

Name ______________________________ Date ____________
Last First Initial

DOB ____________ Gender ____________ Email ____________________

Mailing Address ____________________ City/State/Zip ____________________

Street Address (if different than mailing) ____________________ Phone ____________

Occupation ____________________ City/State/Zip ____________________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/er

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATIONS, IF SELF, INDICATE SELF ☐

Name ____________________ Relationship ____________________ Phone ____________

Mailing Address (if different than patient's) ______________________________

Street Address (if different than patient's) ______________________________

City/State/Zip ______________________________ Employer Name ____________________

IN CASE OF EMERGENCY

Name ____________________ Relationship ____________________ Phone ____________

Street Address ____________________ City/State/Zip ____________________

PRIVACY DISCLOSURE: I HAVE READ THE NOTICE OF PRIVACY PRACTICES SHEET AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Patient Signature ______________________________ **Date** ____________

Eastern Channel Acupuncture

POLICIES & PROCEDURES

I am so pleased to have you as a new patient, welcome! The following information will provide you with my Practice Policies & Procedures:

OFFICE POLICIES:

- Please spend some time thinking about how I can help you today.
- Please arrive on time for your appointment, 15 minutes late is considered missing your appointment.
- I will charge you the full fee for missing an appointment without 24 hours' notice.
- Please turn off cell phones before entering the treatment room.
- Please wear warm, clean, comfortable clothing that can be easily adjusted, and remove your shoes.
- Please have come to your appointment having eaten within the last four hours, and well hydrated.

PROCEDURES:

Chinese medical diagnosis requires accurate and detailed information about your condition and lifestyle. All information on my forms will be held in confidence.
Acupuncture is virtually a painless, highly effective form of Complementary Care.
Typical sensations derived from the needles are:

- Sensations of movement or warmth
- Sensations of heaviness and relaxation
- Sensation of a dull aching
- An increased awareness of your body

After the needles are removed, it is common to feel a bit lightheaded or euphoric.
Try to take your time as you leave the office. If you feel dizzy, let me know I'll be happy to assist you.

PHILOSOPHY:

I believe that wellness is a lifelong investment in oneself and others. I strive to improve the quality of life by sharing the wisdom of Traditional Chinese Medicine, thank you for investing in your health and allowing me the opportunity to assist you with your health care needs.

CONSENT FOR TREATMENT:

I, the undersigned, do hereby request and consent to the performance of Acupuncture and other Oriental Medicine procedures. The methods of treatment may include, but not limited to:

- Acupuncture is an ancient healing art developed in China, used to treat a variety of health problems, and is very safe. A licensed acupuncturist inserts fine, solid, sterile, single-use needles at specific points just below the skin. Risks and side effects of acupuncture include a worsening of symptoms that is usually temporary, minor bruising and or bleeding may occur, and occasionally patients may feel dizzy or faint, and in rare cases lung puncture (pneumothorax) may result.
- Electrical Stimulation is a mild electrical current that may be used with acupuncture needles.
- Moxibustion is an herbal heat therapy that may be used with or without acupuncture, it includes burning herbs on or near the skin. This may cause burning or blistering of the area.
- Cupping is a technique that uses heat and suction with special glass cups. Cupping will cause a discoloration of the skin known as "sha," that will look like a bruise, and should be covered from the elements for about 24 hours.
- Gua Sha is a skin scraping technique that is useful in painful conditions and other illnesses. A spoon or other instrument scrapes the skin and causes a discoloration known as "sha," that should be covered from the elements for about 24 hours.
- Shiatsu and Tuina are traditional massage techniques that may be used alone or with other treatment modalities.
- Herbal Formulas help the body's systems to heal and work more efficiently. Often there is some mild digestive discomfort, or headaches from the herbs. It is important to follow all dosage instructions correctly.

I wish to rely on the acupuncturist to exercise judgment during the course of treatment, which the acupuncturist feels at the time, is in my best interests.
By signing below, I agree to the above procedures. I intend this consent to cover the entire course of treatment for my present condition(s).

Patient Signature ____ **Date** ____________________

Eastern Channel Acupuncture

PERSONAL HEALTH HISTORY

MAIN COMPLAINT ____

____

ALERGIES (drug, food, chemical/environmental) ____________________________

____

MEDICATIONS (please include additional page if necessary) ____________________

____

VITAMINS/SUPPLEMENTS/HERBS (please include additional page if necessary) __________

____

SURGERIES (please include date of procedure) ____________________________

____

DIET Vegetarian ☐ Meals/day _____ Snacks _____

Caffinated drinks/day _____ Alcoholic drinks/day _____

YOUR BIRTH HISTORY (prolonged labor, forceps delivery, etc.) __________________

____

SIGNIFICANT TRAUMA (auto accident, fall, phychological, abuse, etc. ______________

____

EXERCISE Days/week _____ Length of workout ______ Type of activity ______________

PERSONAL HISTORY

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Fibromyalgia/Polymyalgia
- ☐ Gastritis
- ☐ Liver/Gallbladder Disease
- ☐ Diabetes
- ☐ Seizure
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies/Intolerances
- ☐ Hepatitis
- ☐ Thyroid Imbalance
- ☐ Chronic Pain
- ☐ Infertility
- ☐ Heart Disease
- ☐ Elevated Blood Cholesterol
- ☐ Diverticulitis/Irritable Bowels
- ☐ Raynaud's Disease
- ☐ Impotence
- ☐ Emphysema

PERSONAL HEALTH HISTORY (cont.)

FAMILY MEDICAL HISTORY

Please indicate any condition that applies to your immediate family.
Put an **F** (father), **M** (mother), **S** (sister) **B** (brother), **GM** (grandmother), **GF** (grandfather)

______ Diabetes ______ Heart Disease ______ Cancer ______ Stroke/High Blood Pressure

______ Seizures ______ Asthma ______ Allergies ______ Other ______________________

PLEASE CHECK IN YOU HAVE HAD ANY OF THESE SYMPTOMS IN THE LAST 3 MONTHS

GENERAL

- Poor Appetite
- Bleed/Bruise Easily
- Night Sweats
- Thirst (cold/hot drinks)
- Poor Balance
- Tremors
- Chills
- Muscle Weakness/Fatigue
- Localized Weakness
- Fatigue
- Peculiar Tastes/Smells
- Change in Appetite
- Cravings
- Poor Sleep
- Weight Loss/Gain
- Sweat Easily
- Fevers
- Dental/Gum Problems

SKIN AND HAIR

- Rashes
- Ulcerations
- Hives/Allergic Dermatitis
- Moles
- Eczema/Psoriasis
- Dandruff
- Loss of Hair
- Face Flushing
- Skin Discoloration
- Acne
- Itching

HEAD, EARS, NOSE, AND THROAT

- Dizziness
- Eye Strain
- Color Blindness
- Ringing in Ears
- Nosebleeds
- Difficulty Swallowing
- Earaches
- Sores on Lips/Toungue
- Eye Pain
- Cataracts
- Poor Hearing
- Recurrent Sore Throat/Colds
- Dental Problems
- Poor Vision
- Sinus Problems
- Headaches/Migranes (where/when: ______________________
- Blurred Vision
- Spots in Front of Eyes
- Teeth Grinding
- Jaw Clicks/Locks
- Eye Glasses
- Night Blindness
- Facial Pain

CARDIOVASCULAR

- Chest Pain
- Irregular Heartbeat
- Palpitations at Rest
- Phlenitis
- Cold Hands/Feet
- Swelling of Hands/Feet
- Fainting
- Pressure in Chest
- Shortness of Breath
- Varicose/Spider Veins
- Blood Clots

PERSONAL HEALTH HISTORY (cont.)

RESPIRATORY

- Cough
- Coughing Blood
- Pain with Deep Inhalation
- Bronchitis
- Pneumonia
- Asthma
- Tight Sensation in Chest
- Any Other Lung Condition: ____________________
- Difficult to Inhale/Exhale
- Wheezing
- Production of Phlegm

GASTROINTESTINAL

- Nausea
- Bloating/Edema
- Belching
- Acid Reflux
- Rectal Pain
- Constipation
- Abdominal Pain/Crams
- Gas
- Changes in Appetite
- Bad Breath
- Diarrhea
- Loose Stools
- Blood in Stools
- Other: ____________________
- Flatulence
- Vomiting
- Chronic Use of Laxatives
- Black Stools
- Hernia
- Hemorrhoids

UROGENITAL

- Pain on Urination
- Premeture Ejaculation
- Sores on Genitals
- Scanty Flow
- Urgent Urination
- Dribbling After Urination
- Waking to Urinate
- Unable to Hold Urine
- Frequent Urination
- Decreased Libido
- Urinary Tract Infections
- Copious Flow
- Other: ____________________
- Impotence
- Kidney Stones
- Blood in Urine
- Prostatitis
- Burning Urination

What times? ____________ Color of Urine ____________

GYNECOLOGICAL/REPRODUCTIVE

No. of Pregnancies ________ No. of Births ________ No. of Miscarriages ________

No. of Premature Births ________ No. of Abortions ________ Are You Pregnant? ☐ Y ☐ N

Age of First Menses ________ Date of Last Menses ________ Date of Last Pap/Pelvic ________

Do You Practice Birth Control? ☐ Y ☐ N What type? ____________ How Long? ________

- Painful Menses
- Vaginal Sores
- Difficult Intercourse
- Fibroid Tumors
- Irregular Menstuation
- Vaginal Discharge
- Breast Lumps
- Infertility
- Ovarian Cysts
- Vaginal Dryness
- Endometriosis
- Fibrocystic Breast Tissue

PERSONAL HEALTH HISTORY (cont.)

MUSCULOSKELETAL

- [ ] Neck Pain
- [ ] Bursitis
- [ ] Rotator Cuff
- [ ] Back Pain - Upper
- [ ] Hand/Wrist Pain
- [ ] Carpal Tunnel
- [ ] Knee Pain
- [ ] Sprains/Strains
- [ ] Shoulder Pain
- [ ] Back Pain - Middle
- [ ] Sciatica
- [ ] Foot/Ankle Pain
- [ ] Hip Pain
- [ ] Muscle Pain
- [ ] Tendonitis
- [ ] Back Pain - Lower
- [ ] Muscle Weakness

NEUROPSYCHOLOGICAL

- [ ] Seizures
- [ ] Loss of Balance
- [ ] Vertigo/Dizziness
- [ ] Areas of Numbness
- [ ] Lack of Coordination
- [ ] Poor Memory
- [ ] Concussion
- [ ] Depression
- [ ] Anxiety/Panic Attacks
- [ ] Bad Temper/Irritable
- [ ] Easily Susceptible to Stress
- [ ] Seasonal Affective Disorder

Have you ever been treated for emotional problems? ☐ Y ☐ N

Do you have a spiritual life? ☐ Y ☐ N

Have you ever considered or attempted suicide? ☐ Y ☐ N

Have you ever been treated for substance abuse? ☐ Y ☐ N

Any other neurological or psychological conditions? If yes, please explain: ______________________

____

Indicate on the scale your level of satisfaction for each category

	Satisfied										**Distressed**
Family Relationships	○	○	○	○	○	○	○	○	○	○	○
Intimate Relationships	○	○	○	○	○	○	○	○	○	○	○
Work Relationships	○	○	○	○	○	○	○	○	○	○	○

Please indicated any additional painful or distressed areas: ______________________

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