February 2019

ACUPUNCTURE - INTAKE FORM

BEACON HILL
CHIROPRACTIC AND MASSAGE

Full Name: _____ ***M / F*** ***AHC #:*** _____

Date of Birth (M/D/Y): _____ **Age:** _____ **Occupation:** _____

Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____

Home phone: _____ **Cell phone:** _____ **Work Phone:** _____

◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Separated** ◯ **Widowed** **Children? Y / N** **How Many?:** _____

Name of Spouse: _____ **Phone Number:** _____

Alternate Emergency Contact: _____ **Phone Number:** _____

If under 18, Name of Parents: _____

Do you consent to emails regarding appointment reminders and clinic/health information? ___ Yes ___ No

Email: _____ **Initials:** _____

How were you referred to Beacon Hill Chiropractic & Massage?

◯ Online ◯ Website ◯ Walk by ◯ Lives in area ◯ Person: _____

◯ Current patient: _____

REASON FOR THIS VISIT

Please describe the reason for your visit: _____

When did this condition begin? _____ Has it gotten: ◯ Worse ◯ Better ◯ Same ◯ Comes/goes

What makes it better? _____ Worse? _____

Does your pain interfere with your sleep? ◯ Yes ◯ No ◯ Sometimes Physical activity? ◯ Yes ◯ No ◯ Sometimes

Please list any current or previous treatments for this problem: _____

Have you seen anyone else for this condition? Doctor/clinician's name: _____

Type of treatment: _____ Result: _____

Is your pain: ◯ Aching ◯ Stabbing ◯ Sharp ◯ Throbbing ◯ Tingling ◯ Numb ◯ Electric

How bad is your pain on a scale of 1-10, (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Location of pain: _____ Frequency? _____

ABOUT YOU

Past motor vehicle accident? ◯ Yes ◯ No Date of accident: _____

Past traumas/injuries (physical or emotional): _____

Past surgeries? ◯ Yes ◯ No Please list: _____

_____

Do you have any **allergies**, suspected allergies, or sensitivities? Please list and explain: _____

_____

Please list all **medications** and **nutritional supplements** you are currently taking: _____

_____

List what you do for **physical activity** and frequency: _____

_____

FULL NAME: _____

Body Function
- ◯ Blood pressure: HIGH
- ◯ Blood pressure: LOW
- ◯ Burning hands/feet
- ◯ Chest pain
- ◯ Cold hands/feet
- ◯ Easy bleeding
- ◯ Hot flashes
- ◯ Numbness in hands/feet
- ◯ Pacemaker
- ◯ Poor circulation
- ◯ Recent weight gain/loss
- ◯ Slow to heal
- ◯ Taking anti-coagulants
- ◯ Thyroid imbalance
- ◯ Usually cold
- ◯ Usually warm
- ◯ Weakened immune system

Sleep
- ◯ Difficulty getting to sleep
- ◯ Difficulty staying asleep
- ◯ Difficulty waking
- ◯ Easily woken up
- ◯ Energy: POOR
- ◯ Energy: TOO MUCH
- ◯ Nightmares
- ◯ Restless at night
- ◯ Sleep: POOR/NOT RESTED
- ◯ Sleep: POORLY
- ◯ Sleep: WELL/FEEL RESTED
- ◯ Vivid dreams
- ◯ Hours of sleep: _____ /night
- ◯ Bedtime: _____
- ◯ Wake time: _____
- ◯ Naps? _____

Food & Beverage Consumption
- ◯ Prefer: WARM food/beverages
- ◯ Prefer: COLD food/beverages
- ◯ Always thirsty
- ◯ Cravings
- ◯ Appetite: EXCESSIVE
- ◯ Appetite: POOR
- ◯ Abdominal discomfort
- ◯ Bloating/gassy
- ◯ Nausea/vomiting
- ◯ Acid reflux/heartburn
- ◯ Fluid consumed: _____ /day

Airway
- ◯ Acute cough
- ◯ Asthma
- ◯ Chronic cough
- ◯ Emphysema/COPD
- ◯ Frequent colds/flu
- ◯ Runny nose
- ◯ Shortness of breath
- ◯ Sore throat

Head & Neck
- ◯ Epilepsy/seizures/fainting
- ◯ Jaw ache/pain
- ◯ Headaches: BACK OF HEAD
- ◯ Headaches: BEHIND EYES
- ◯ Headaches: SIDE OF HEAD
- ◯ Headaches: TOP OF HEAD
- ◯ Migraines
- ◯ Poor memory/concentration
- ◯ Sinus problems
- ◯ Frequency of headaches or migraines: _____ /day

Eyes
- ◯ Blurred vision
- ◯ Floaters
- ◯ Dry eyes
- ◯ Burning eyes
- ◯ Red eyes
- ◯ Itchy eyes

Ears & Balance
- ◯ Ringing in ears
- ◯ Hearing loss
- ◯ Dizziness / vertigo
- ◯ Impaired balance

Skin & Sweat rate
- ◯ Dry hair/nails
- ◯ Easy bruising
- ◯ Eczema/dermatitis
- ◯ Facial/body acne
- ◯ Skin rash
- ◯ Never sweat
- ◯ Night sweats
- ◯ Spontaneous sweating
- ◯ Sweat with emotional stress

Digestive area
- ◯ Alternating constipation/diarrhea
- ◯ Bowel movements: PAINFUL
- ◯ Bowel movements: URGENT
- ◯ Constipation
- ◯ Diarrhea
- ◯ Hemorrhoids
- ◯ Stool: BLOOD/MUCUS
- ◯ Stool: FIRM/HARD
- ◯ Stool: LOOSE

- ◯ Frequency of bowel movements: _____ /day

Urinary system
- ◯ Bedwetting
- ◯ Genital irritation or UTI
- ◯ Incontinence/dribbling
- ◯ Kidney stones
- ◯ Urinate at night
- ◯ Urination: DIFFICULT/SCANT
- ◯ Urination: FREQUENT
- ◯ Urination: PAINFUL
- ◯ Urination: URGENT
- ◯ Urine: BLOODY
- ◯ Urine: DARK/CLOUDY
- ◯ Urine: UNUSUAL ODOR

Males only
- ◯ Enlarged prostate
- ◯ Erectile dysfunction
- ◯ STD
- ◯ Change in libido

Females only
- ◯ Change in libido
- ◯ Menopausal
- ◯ Number of abortions: _____
- ◯ Number of miscarriages: _____
- ◯ Number of pregnancies: _____
- ◯ Period: AGE OF START: _____
- ◯ Period: CYCLE LENGTH: _____
- ◯ Period: DURATION: _____ days
- ◯ Period: HEAVY FLOW/CLOTS
- ◯ Period: IRREGULAR PERIOD
- ◯ Period: LIGHT FLOW
- ◯ Period: SPOTTING BETWEEN
- ◯ PMS
- ◯ Pregnant now or trying
- ◯ Vaginal dryness

Please read and sign:

THIS AGREEMENT AND THE CONTENTS OF THIS FILE ARE CONFIDENTIAL. DATA WILL NOT BE SHARED OUTSIDE OF BEACON HILL CHIROPRACTIC AND MASSAGE WITHOUT CLIENT PERMISSION. THE INFORMATION DISCLOSED IS TO ASSIST YOUR ACUPUNCTURIST IN PROVIDING THE SAFEST AND MOST EFFECTIVE TREATMENT PLAN FOR YOU.

I understand the methods of treatment may include, but are not limited to acupuncture, acupressure, moxibustion, cupping, essential oils, electrical stimulation, tui-nam (Chinese massage), gua-sha, exercise prescription and lifestyle counseling. I understand that results are not guaranteed.

Potential benefits of these treatments may allow for the painless relief of one's current symptoms, as well as improving balance of the body's muscles/fascia, and blood flow. Potential risks associated with acupuncture include slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, numbness, fainting, or nausea. Cupping commonly leaves painless, dark circular marks on the skin which fades within 3-7 days. Very rare and unusual risks of acupuncture include miscarriage, nerve damage and organ punctures. I will inform my acupuncturist if I have any condition and/or if I am taking any medication that interferes with blood clotting.

Herbal remedies – Herbal formulas (plant, animal, and mineral sourced) that have been recommended are considered safe in the practice of Traditional Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking these remedies are nausea, gas, stomachache, headache, diarrhea, and tingling of the tongue. I will notify my acupuncturist if I experience any of the above-mentioned side effects or if I become pregnant.

Disposable needles – To reduce the possibility of infection from acupuncture, all needles are pre-sterilized-one-time-use needles made of surgical stainless steel. After each treatment they are disposed of as medical waste, never re-used. Your acupuncturist has had training in clean needle technique and universal precautions.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interest. I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that any treatment provided by the acupuncturist when requested without a chiropractic preliminary exam/assessment, is separate and distinct from the practice of chiropractic provided by the chiropractors of Beacon Hill Chiropractic & Massage. I hereby waive all liability towards the above mentioned chiropractors directly or indirectly associated with Beacon Hill Chiropractic & Massage, should any injury or malpractice occur from any treatment provided by the acupuncturist.

I have also had the opportunity to ask questions about the content of this consent form, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

I understand that payment is expected at the time of service AND that if I fail to cancel an appointment <u>24 hours in advance</u>, or have missed an appointment, I will be charged the following cancellation fees:

First Time – Warning
Second Time – <u>100%</u> of massage price

_____
Initial

***I have read the above noted consent**, I have had the opportunity to consider the benefits and risks associated with acupuncture and I am choosing to continue with treatment. By signing this form, I confirm consent to treatment within the scope of Traditional Chinese Medicine (TCM) for me (or the patient named below, for whom I am legally responsible) by my doctor of acupuncture. I intend consent to cover any and all related in-clinic treatments and home care plans proposed by my acupuncturist. I understand I am able to withdraw my consent and treatment will be stopped at any time.*

_____	_____	_____
Patient Full Name (Print Legibly)	*Signature*	*Date (M/D/Y)*

***If under the age of 18:**

_____	_____	_____
Parent Name (Print Legibly)	*Signature*	*Date (M/D/Y)*

_____	_____
Doctor of Acupuncture Signature	***Date (M/D/Y)***