June 2024

# ACUPUNCTURE - INTAKE FORM

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

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

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

**Cell phone:** _____ **Home 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 ◯ Other: _____ ◯ Current patient: _____

Have you received acupuncture before? ◯ Yes ◯ No From who? ◯ Chiro ◯ Physio ◯ TCM Acupuncturist
Why: _____

## 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: _____

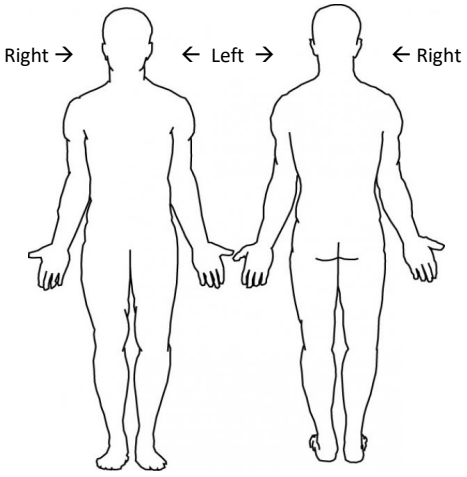
Have you seen anyone else for this condition? Doctor/clinician: _____
Type of treatment: _____ Result: _____

What are your goals for care? _____

## PAIN/DISCOMFORT DIAGRAM:

Please mark these diagrams according to where you feel pain or any sensations listed in the key below

| KEY |
|---|
| ///// Stabbing |
| XXXX Aching |
| #### Burning |
| >>>> Pins/Needles |
| 0000 Numbness |
| ???? Throbbing |
| ZZZZ Electric |




How frequent is your pain?
_____
_____

How long does it last?
_____
_____

**PLEASE CIRCLE YOUR CURRENT PAIN LEVEL**
0 1 2 3 4 5 6 7 8 9 10

**0-3** – No pain; Mild pain
**4-7** – Moderate pain; medication required
**8-10** – Severe pain; daily life impacted

FULL NAME: _____

Please **CHECK** any current/past conditions

**1. BODY FUNCTION**
- ◯ Blood pressure: HIGH
- ◯ Blood pressure: LOW
- ◯ Chest pain
- ◯ Easy bleeding
- ◯ Hands/Feet: BURNING
- ◯ Hands/Feet: COLD
- ◯ Hands/Feet: NUMBNESS
- ◯ Hot flashes
- ◯ Pacemaker
- ◯ Poor circulation
- ◯ Recent weight gain/loss
- ◯ Slow to heal
- ◯ Taking anti-coagulants
- ◯ Thyroid imbalance
- ◯ Usually cold
- ◯ Usually warm
- ◯ Weak immune system

**2.SLEEP**
- ◯ Difficulty falling asleep
- ◯ Difficulty staying asleep
- ◯ Difficulty waking
- ◯ Do you wake at night? What time? _____
- ◯ Easily woken up
- ◯ Insomnia
- ◯ Nightmares
- ◯ Poor/not rested
- ◯ Restless at night
- ◯ Snoring
- ◯ Vivid dreams
- ◯ Well/feel rested
- ◯ Bedtime: _____
- ◯ Wake time: _____
- ◯ Hours: _____ /night

**11.ENERGY**
- ◯ Energy: POOR
- ◯ Energy: SLUGGISH
- ◯ Energy: TOO MUCH
- ◯ Naps? _____

**4.HEAD & NECK**
- ◯ Epilepsy/seizures/fainting
- ◯ Headache: BACK OF HEAD
- ◯ Headache: BEHIND EYES
- ◯ Headache: SIDE OF HEAD
- ◯ Headache: TOP OF HEAD
- ◯ Migraines
- ◯ Frequency headaches or migraines: _____ /day
- ◯ Jaw ache/pain
- ◯ Poor memory/concentration
- ◯ Sinus problems

**5.AIRWAY**
- ◯ Acute cough
- ◯ Asthma
- ◯ Chest heaviness
- ◯ Chronic cough
- ◯ Emphysema/COPD
- ◯ Frequent colds/flu
- ◯ Frequent sighing
- ◯ Heart palpitations
- ◯ Runny nose
- ◯ Shortness of breath
- ◯ Sore throat

**6. SKIN & SWEAT RATE**
- ◯ Dry hair/nails
- ◯ Easy bruising
- ◯ Eczema/dermatitis
- ◯ Facial/body acne
- ◯ Never sweat
- ◯ Night sweats
- ◯ Skin rash
- ◯ Spontaneous sweating
- ◯ Sweat w/ emotional stress

**7.EARS AND BALANCE**
- ◯ Dizziness / vertigo
- ◯ Ear infections
- ◯ Hearing loss
- ◯ Impaired balance
- ◯ Ringing in ears

**8.FOOD/BEVERAGE**
- ◯ Abdominal discomfort
- ◯ Acid reflux/heartburn
- ◯ Always thirsty
- ◯ Appetite: EXCESSIVE
- ◯ Appetite: POOR
- ◯ Bloating/gassy
- ◯ Cravings: BITTER
- ◯ Cravings: PUNGENT
- ◯ Cravings: SALTY
- ◯ Cravings: SOUR
- ◯ Cravings: SWEET
- ◯ Fluid consumed: _____ /day
- ◯ Nausea/vomiting
- ◯ Pain along sides of abdomen
- ◯ Prefer: COLD food/beverages
- ◯ Prefer: WARM food/beverages

**9.DIGESTIVE AREA**
- ◯ Alternating constipation/diarrhea
- ◯ Bowel movements: PAINFUL
- ◯ Bowel movements: URGENT
- ◯ Constipation
- ◯ Diarrhea
- ◯ Frequency of bowel movements: _____ /day
- ◯ Hemorrhoids
- ◯ Stool: BLOOD/MUCUS
- ◯ Stool: FIRM/HARD
- ◯ Stool: LOOSE

**10.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

**3.EYES**
- ◯ Blurred vision
- ◯ Burning eyes
- ◯ Dry or itchy eyes
- ◯ Floaters
- ◯ Red eyes

**12. STRESS**
- ◯ Stress: HIGH
- ◯ Stress: LOW
- ◯ Stress level: 1-2-3-4-5-6-7-8-9-10
- ◯ Addiction
- ◯ Anxiety
- ◯ Depression
- ◯ Eating disorder
- ◯ Emotions: ANGER
- ◯ Emotions: FEAR
- ◯ Emotions: JOY
- ◯ Emotions: SADNESS
- ◯ Emotions: WORRY
- ◯ Panic attacks

**13.WOMEN ONLY**
- ◯ Change in libido
- ◯ Menopausal
- ◯ Period: Age @ 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
- ◯ # of abortions: _____
- ◯ # of miscarriages: _____
- ◯ # of pregnancies: _____
- ◯ Vaginal dryness

**14. MEN ONLY**
- ◯ Change in libido
- ◯ Enlarged prostate
- ◯ Erectile dysfunction
- ◯ STD

**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 all **medications/nutritional supplements** you are currently taking: _____

_____

What do you do for **physical activity** and frequency: _____

Do you smoke cigarettes? ◯ Yes ◯ No Cannabis? ◯ Yes ◯ No How often? _____

Do you drink alcohol? ◯ Yes ◯ No How often? _____

BEACON HILL
CHIROPRACTIC AND MASSAGE

## 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.

_____
*Initial*

I understand that payment is expected at the time of service.

I understand that as per clinic policy, **any appointment which I miss or fail to cancel 24 hours in advance will be subject to the following cancellation fees:**

**First Time – Warning**
**Second Time – <u>100%</u> of appointment fee**

_____
*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)* |
| _____ | _____ | _____ |
| *Parent Name (*If patient under the age of 18)* | *Signature* | *Date (M/D/Y)* |
| _____ | _____ | |
| ***Doctor of Acupuncture Signature*** | ***Date (M/D/Y)*** | |