Stamps Chiropractic | Heather Brookman, LAc

Acupuncture and Traditional Chinese Medicine Intake Form

Full Name: _____ Date of Birth: _____

Contact Information

Street/Mailing Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

The acupuncturist may need to follow-up with you regarding your care after your treatment. Your preferred method of contact: ☐ text ☐ email

Emergency Contact Name: _____

Emergency Contact Relation to You: _____

Emergency Contact Phone Number: _____

Whom do we thank for referring you? _____

Do we have permission to thank them? ☐ Yes ☐ No

Your Occupation: _____

Your Employer: _____

Top 3 Health Concerns

1. _____
2. _____
3. _____

Treatments Tried for Health Concerns

_____

_____

_____

_____

_____

Allergies:

_____

_____

Medications (attach list if necessary):

_____

_____

_____

Supplements (attach list if necessary):

_____

_____

_____

Have you had acupuncture before? ☐ Yes ☐ No If so, when was the last treatment? _____

Do you have or have you had any of the following conditions (please check all that apply):

- ❑ Acute Viral Infections (HIV, HPV, Hepatitis, Herpes)
- ❑ Adrenal Fatigue
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Breast Lumps
- ❑ Cancer
- ❑ Candida
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Chronic Viral Infections (HIV, HPV, Hepatitis, Herpes)
- ❑ Diabetes
- ❑ Emphysema/COPD
- ❑ GERD
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Infertility
- ❑ Insomnia
- ❑ Irregular Heart Beat
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Measles/Mumps/Rubella
- ❑ Migraines
- ❑ MS
- ❑ Pacemaker
- ❑ Parkinson's
- ❑ Pneumonia/Bronchitis
- ❑ Polio
- ❑ Prostate Problems
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Disease
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Trauma (Emotional)
- ❑ Trauma (Physical)
- ❑ Tuberculosis
- ❑ Ulcers

Please provide any important details regarding your medical condition(s):

_____

_____

_____

Please list any serious illnesses, hospitalizations, or surgeries:

_____

_____

Review of Systems

General

- ❑ Depression
- ❑ Fatigue
- ❑ Anxiety
- ❑ Stress
- ❑ Difficulty Sleeping
- ❑ Headaches
- ❑ Weight Changes
- ❑ Hypersensitivities
- ❑ Other _____

Muscle/Joint/Bone (Pain/Weakness/Numbness).

Please provide details, including pain level on a scale of 1-10:

Head _____
Neck _____
Shoulder _____
Arm _____
Wrists _____
Elbow _____
Hand _____
Upper Back _____
Mid Back _____
Low Back _____
Hips _____
Legs _____
Knees _____
Ankles _____

Neurological:

- ❑ Neuropathy
- ❑ Tremors
- ❑ Nerve Pain (location)
- ❑ Changes in Memory
- ❑ Changes in function after a stroke _____

Eye/Ear/Nose/Throat:

- ❑ Swallowing Difficulty
- ❑ Hoarseness
- ❑ Persistent Sore Throat
- ❑ Double or Blurry Vision
- ❑ Vision-Flashes or Halos
- ❑ Earache/Ear Discharge
- ❑ Hearing Loss
- ❑ Ringing in the Ears
- ❑ Persistent Cough
- ❑ Sinus Problems
- ❑ Hay Fever
- ❑ Nosebleeds

Gastrointestinal

- ❑ Poor Appetite
- ❑ Extreme Hunger
- ❑ Extreme Thirst
- ❑ Bloating
- ❑ Bowel Changes
- ❑ Constipation
- ❑ Loose Stool
- ❑ Diarrhea
- ❑ Painful Bowel Movement
- ❑ Gas
- ❑ Stomach Pain
- ❑ Indigestion
- ❑ Nausea
- ❑ Hemorrhoids
- ❑ Rectal Bleeding
- ❑ Vomiting
- ❑ Bad Breath
- ❑ Bleeding Gums

Cardiovascular

- ❑ Chest Pain
- ❑ Palpitations
- ❑ Poor Circulation
- ❑ Ankle Swelling
- ❑ Varicose Veins
- ❑ Fainting/Dizziness

Respiratory

- ❑ Cough
- ❑ Wheeze
- ❑ Coughing Up Phlegm
- ❑ Shortness of Breath

Genitourinary

- ❑ Blood in Urine
- ❑ Cloudy Urination
- ❑ Frequent Urination
- ❑ Poor Bladder Control
- ❑ Painful/Burning Urination
- ❑ Strong Urge to Urinate
- ❑ Difficulty Starting Urination
- ❑ Weak Urinary Stream
- ❑ Incomplete Emptying of the Bladder

Skin

- ❑ Bruise Easily
- ❑ Hives
- ❑ Itching
- ❑ Rashes
- ❑ Mole changes
- ❑ Sores
- ❑ Scars (provide location) _____

Men

- ❑ Erection Difficulty
- ❑ Lump in Testicle
- ❑ Penile Discharge
- ❑ Sores on Penis
- ❑ Problems with Fertility

Women

- ❑ Abnormal Pap Smear
- ❑ Painful Intercourse
- ❑ Vaginal Discharge
- ❑ Breast Lumps
- ❑ Nipple Discharge
- ❑ Hot Flashes
- ❑ Bleeding Between Periods
- ❑ Severe Menstrual Pain
- ❑ PMS/PMDD
- ❑ Heavy Menstrual Flow
- ❑ Perimenopausal Symptoms
- ❑ Problems with Fertility

Please notify the acupuncturist if you are undergoing fertility treatments or would like help with fertility.

Any other comments or concerns

_____

_____

_____

_____

_____

Stamps Chiropractic | Heather Brookman, LAc

Acupuncture and Traditional Chinese Medicine

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Notification Form regarding Evaluation of Patient by Physician

(Pursuant to the requirement of 22 T.A.C section 183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ Code Ann, section 205.351, governing the practice of Acupuncture)

I (patient's name), _____ am notifying Stamps Chiropractic and Heather Brookman, LAc. of the following:

Yes _____ No _____ I have been evaluated by a physician or dentist, for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

Yes_____ No_____ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:
____ Chronic pain ____ Smoking addiction ____ Weight loss ____ Alcoholism ____ Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

_____

Patient Signature (required) Date

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The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice

_____

Patient Signature (required) Date

_____

Acupuncturist Signature Date

Stamps Chiropractic and Heather Brookman, LAc are not responsible for untrue statements made by patients.

Stamps Chiropractic | Heather Brookman, LAc
Acupuncture and Traditional Chinese Medicine
Informed Consent for Treatment

I, _____, hereby request and consent to treatment by acupuncture and/ or procedures within the scope of the practice of Acupuncture and Chinese Medicine by *Heather Brookman, LAc.*

I am hereby informed that the aforementioned methods are all generally safe, but that there may be some side effects or risks, as follows:

- Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling.
- I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.
- I understand that I can discuss risks and benefits further before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment.
- I fully understand that there is no implied or stated guarantee of success of effectiveness of a specific treatment of series of treatments.
- I understand that my practitioner will keep all of my records confidential.
- I release Stamps Chiropractic and Heather Brookman, LAc from any unforeseen liability that may occur from receiving consultation and treatment with acupuncture.

In signing this form I acknowledge any inherent risks and give my consent for treatment, healthcare operations received, incurred or carried out by my practitioner.

Printed Name of Patient or Responsible Party:

_____

Signature of Patient or Responsible Party:

_____

Date Signed: _____