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ACUPUNCTURE INTAKE - ADULT

Name: _____ Date of Birth: _____ Date of Service: _____

Do you see any of our other providers at Elevate Health? ☐ Yes ☐ No
If yes, which provider(s)? _____

Are you currently receiving healthcare from any providers outside of Elevate Health? ☐ Yes ☐ No
If yes, please list providers' names and type of practitioner(s): _____

_____

If no, when and where did you last receive healthcare? _____

What was the reason? _____

Have any of your family members been seen at Elevate Health? ☐ Yes ☐ No

If yes, what are their names? _____

HEALTH CONCERNS

What are your top health concerns/goals? Please list in order of importance:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

What is your present level of commitment to correct your health concerns? *(10 = 100% committed.)*

0 1 2 3 4 5 6 7 8 9 10

Do you have any known contagious illnesses at this time? ☐ Yes ☐ No If yes, what? _____

_____

ALLERGIES

☐ No Known Allergies

Are you hypersensitive or allergic to:

Any drugs? ☐ Yes ☐ No _____

Any foods? ☐ Yes ☐ No _____

Any environmental or chemical allergens? ☐ Yes ☐ No _____

HEALTH HISTORY

ILLNESS/INJURY/SURGERY/HOSPITALIZATIONS: Please list any serious illnesses, injuries, surgeries, or hospitalizations you have had and the year they occurred:

Illness/Injury/Surgery/Hospitalization	Year	Illness/Injury/Surgery/Hospitalization	Year

TRAUMA: Please list any significant traumatic events your have experienced and dates of occurrence (e.g. divorce, injury, family loss, bankruptcy, etc.):

Event	Date	Event	Date

CHILDHOOD ILLNESSES: Where you often ill as a child? ☐ Yes ☐ No
Please list any childhood illnesses:

Illness	Date	Illness	Date

CURRENT MEDICATIONS & SUPPLEMENTS: Please list any prescription **medications**, **over-the-counter medications**, **vitamins** or other **supplements** you are taking (attach an extra page if you need more room):

_____ _____ _____

_____ _____ _____

_____ _____ _____

MUSCULOSKELETAL/PAIN MANAGEMENT **(Complete if you are seeking treatment for pain)**

Where is your pain located?_____ Does it move, where?_____
Onset of pain:_____ Rate pain 1-10 (10=worst pain):_____ How often does it occur?_____
What event/events led to your pain?_____
What factors affect your pain? (Check B if it makes it Better or W if it makes it Worse):

Heat:	☐ B	☐ W	Sitting:	☐ B	☐ W	Soft Pressure:	☐ B	☐ W
Cold:	☐ B	☐ W	Standing:	☐ B	☐ W	Hard Pressure:	☐ B	☐ W
Noise:	☐ B	☐ W	Walking:	☐ B	☐ W	Laying Down:	☐ B	☐ W
Coughing:	☐ B	☐ W	Anxiety/Emotions:	☐ B	☐ W	Weather Changes:	☐ B	☐ W

Particular Positions (please describe):_____
Does your pain affect your life? ☐ Yes ☐ No If yes, please describe:_____
_____

FAMILY HISTORY (Please list any family physical or mental health illnesses and age of death:

Mother:_____

Father:_____

Grandparents:_____

Siblings:_____

Children:_____

LIFESTYLE HABITS

Describe your typical diet:

Breakfast:_____ Lunch:_____

Dinner:_____ Snacks:_____

Specific Restrictions/Diet Types:_____

Do you:	Yes	No	
Exercise?	☐	☐	Describe exercise:
Watch TV?	☐	☐	How many hours weekly?
Read books?	☐	☐	How many hours weekly?
Computer games/browsing?	☐	☐	How many hours weekly?
Spiritual/religious practice?	☐	☐	Describe:
Smoke cigarettes?	☐	☐	How much?
Smoke cigarettes in the past?	☐	☐	How many years?____How many packs?____
Eat out often?	☐	☐	How many meals per week?
Drink coffee?	☐	☐	How many cups per day?
Drink tea?	☐	☐	How many cups per day?
Drink soda?	☐	☐	How many cups per week?
Eat sugar?	☐	☐	How much?
Drink alcohol?	☐	☐	How many alcoholic drinks per week?
Use recreational drugs?	☐	☐	What and how often?
Have an addiction?	☐	☐	To what and how long?
Average 6-8 hours sleep?	☐	☐	
Have a supportive relationship?	☐	☐	
Have a history of abuse?	☐	☐	
Spend time outside?	☐	☐	
Take vacations?	☐	☐	
Enjoy your work?	☐	☐	
What is the major source of stress in your life?			
What is the major source of joy in your life?			
If you have traveled outside of the U.S. in the past 12 months, please detail where you went and when:			

SYMPTOMS

Please check the box if you have the symptoms currently or if you have had them in the past.

Spleen/Stomach

- ☐ Body heaviness
- ☐ Hard to get up in morning
- ☐ Muscles often feel tired
- ___ Energy Level: 1-10 (10=high)
- ☐ Easy bruising/bleeding
- ☐ Sweetish taste in mouth
- ☐ Tendency to gain weight
- ☐ Crave sweet tastes
- ☐ Excess/low appetite (circle one)
- ☐ Excess/low thirst (circle one)
- ☐ Nausea/vomiting
- ☐ Gas/belching
- ☐ Hemorrhoids
- ☐ Organ prolapse (ie uterus)
- ☐ Mouth ulcers
- ☐ Over-thinking/worry
- ☐ Swelling in hands
- ☐ Swelling in feet
- ☐ Lack of taste
- ☐ Chronic loose stool
- ☐ Abdominal pain
- ☐ Indigestion/heartburn
- ☐ Brain fog
- ☐ Bad breath

Heart/Small Intestines

- ☐ Rapid or irregular heartbeat
- ☐ Heart palpitations
- ☐ Crave bitter tastes
- ☐ Insomnia/sleep problems
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anxiety/nervous/restless
- ☐ Vivid dreams/nightmares
- ☐ Chest pain
- ☐ Easily startled
- ☐ Red completion
- ☐ Dark urine

Liver/Gallbladder

- ☐ PMS/menstrual problems
- ☐ Feeling of lump in throat
- ☐ Tend to be irritable/angry
- ☐ Bitter taste in mouth
- ☐ Depression/stress
- ☐ Headaches/migraines
- ☐ Red/dry/itchy eyes
- ☐ Visual problems/blurred eyes
- ☐ Pain below ribcage
- ☐ Soft/brittle nails
- ☐ Clenching teeth at night
- ☐ Muscle cramping/twitching
- ☐ Neck/shoulder pain/tightness
- ☐ Dizziness
- ☐ Gall stones
- ☐ Tendonitis
- ☐ Crave sour tastes
- ☐ Seizures/tremors
- ☐ Poor circulation

Lung/Large Intestine

- ☐ Bloody cough
- ☐ Dry cough
- ☐ Chronic cough
- ☐ Cough with sputum
- ☐ White nasal discharge
- ☐ Yellow nasal discharge
- ☐ Green nasal discharge
- ☐ Post nasal drip
- ☐ Grief/sadness
- ☐ Sinus infection/congestion
- ☐ Itchy, red, or painful throat
- ☐ Skin rashes, hives
- ☐ Shortness of breath
- ☐ Allergies/asthma
- ☐ Black or bloody stools
- ☐ Dry mouth/nose/throat
- ☐ Crave pungent or spicy tastes
- ☐ Snoring
- ☐ Bronchitis
- ☐ Constipation
- ☐ IBS
- ☐ Diarrhea
- ☐ Colitis/spastic colon
- ☐ Low immunity
- ☐ Catch colds easily

Kidney/Urinary Bladder

- ☐ Bladder infection
- ☐ Weakness/pain in low back
- ☐ Cold hands/feet
- ☐ Poor memory
- ☐ Hot flashes/night sweats
- ☐ Crave salt
- ☐ Urinary problems (ie night-time)
- ☐ Feel cold or hot easily (circle)
- ☐ Hair loss/grey hair
- ☐ Hearing problems/tinnitus
- ☐ Premature ejaculation
- ☐ Fear
- ☐ Incontinence
- ☐ Osteoporosis
- ☐ Thyroid problems
- ☐ Cavities
- ☐ Impotence

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CONSENT FOR TREATMENT – ACUPUNCTURE

I request and give consent to the performance of acupuncture treatment and other procedures within the scope of practice of acupuncture on me (or the person named below, for whom I am legally responsible) by the acupuncturist employed at Elevate Health, LLC.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, gua sha, electrical stimulation, heat, Tuina (Chinese massage), and herbal medicine.

I understand that a series of acupuncture treatments are usually required to significantly change a condition and receive benefit. Some medications and habits are known to lessen acupuncture results. These may include tobacco, alcohol, narcotics, and steroids.

I have been informed that acupuncture is a generally safe method of treatment, but it may have some risks and side effects including numbness, tingling, bruising, bleeding, swelling, fainting, and infection. Minor bruising and bleeding are common and to be expected as the body responds to acupuncture treatment. Burns are possible with some forms of cupping therapy or heat lamps. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, organ puncture including lung puncture (pneumothorax). Herbs and supplements may be associated with allergic reactions. Other side effects and risks may occur with acupuncture, electrical stimulation, herbs and supplements, and manual therapy including cupping and gua sha.

If I suspect that I am pregnant, I will immediately inform the practitioner.

I understand that there may be limitations to the care provided and that I may be referred to another practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the practitioner to anticipate and explain all possible risks and complications, and I permit the practitioner to determine and/or alter the course of treatment which the practitioner judges to be in my best interests based upon the facts then known.

I understand the side effects and potential dangers involved in treatment by means of acupuncture, cupping, gua sha and other supportive modalities. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my condition and for any future conditions for which I seek help.

Patient's Signature	Date	Guardian/Representative's Signature	Date

Print Patient's Name	Relationship to Patient/Representative Authority