

Today's Date: _____

Name: _____ Referred By: _____

Mailing Address: _____ Postal Code: _____

Phone Number: _____ Cell Phone: _____

Email: _____ Birth Date: _____ Age: _____

Height: _____ Weight: _____ Blood Pressure: _____ Gender: _____

Marital Status: _____ Occupation: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Date of Last Physical Exam: _____ Family Physician: _____ Phone: _____

Have you been treated by Acupuncture or Chinese Medicine before? _____

What was your experience: _____

What is the primary reason for seeking care at our office today? _____

What was the initial cause? _____

When did it begin: _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities? Work Sleep Walking Sitting Standing Moods Relationships Social Life Recreation Stretching Other: _____

Are there any other therapies which you are involved in for this problem? Please list: _____

Are you interested in: Pain Relief Preventative Care Treatment of Illness Herbal Therapy Maintenance Care Stress Relief Chinese Nutritional Advice Other: _____

What is your health goal through the treatment at this office? _____

List any past or future surgeries & dates : _____

List any significant trauma & when it occurred (eg car accident, falls, emotional, abuse etc): _____

List exercise and sport activities you have been or are currently involved in: _____

What are your hobbies? _____

Patient's initials: _____

Medical History

Do you have any allergies? YES NO If so, to what: _____

Do you take any medication? YES NO If so, what types and how often? _____

Do you take any supplements? YES NO If so, what types and how often? _____

Please complete the following as accurately as possible whether in the past (underline) or present (check mark):

<input type="radio"/> Epstein barr virus (EBV)	<input type="radio"/> Thyroid disorder
<input type="radio"/> Cold sores	<input type="radio"/> Kidney stones
<input type="radio"/> Genital herpes	<input type="radio"/> Gynecological disorder
<input type="radio"/> Heart disease	<input type="radio"/> Congenital abnormalities
<input type="radio"/> Rheumatic fever	<input type="radio"/> Skin diseases
<input type="radio"/> High blood pressure	<input type="radio"/> Elevated cholesterol
<input type="radio"/> Heart attack	<input type="radio"/> Cardiac pacemaker
<input type="radio"/> Stroke	<input type="radio"/> Surgical implants
<input type="radio"/> Kidney disease	<input type="radio"/> Change in bowels or bladder habits
<input type="radio"/> Urinary bladder problems/infections	<input type="radio"/> Sores that will not heal
<input type="radio"/> Diabetes	<input type="radio"/> Unusual bleeding or discharge
<input type="radio"/> Cancer	<input type="radio"/> Indigestion
<input type="radio"/> Pneumonia	<input type="radio"/> Parasites
<input type="radio"/> Emphysema	<input type="radio"/> Sjogren's disease
<input type="radio"/> Tuberculosis	<input type="radio"/> Crohn's disease
<input type="radio"/> Asthma	<input type="radio"/> Irritable bowel disease
<input type="radio"/> Peptic ulcer	<input type="radio"/> Lupus erythamtois
<input type="radio"/> Anemia or other blood disorder	<input type="radio"/> Difficulty swallowing
<input type="radio"/> Bleeding disorder	<input type="radio"/> Drug reaction
<input type="radio"/> Blood transfusion	<input type="radio"/> Obvious change in a wart or mole
<input type="radio"/> Fibromyalgia	<input type="radio"/> Osteoporosis
<input type="radio"/> Osteoarthritis	<input type="radio"/> Alzheimer's
<input type="radio"/> Rheumatoid arthritis	<input type="radio"/> Parkinson's

Patient's initials: _____

<ul style="list-style-type: none"> <input type="radio"/> Mental disorder <input type="radio"/> Gout <input type="radio"/> Hepatitis <input type="radio"/> Liver cirrhosis <input type="radio"/> Gall stones <input type="radio"/> Jaundice <input type="radio"/> Hernia <input type="radio"/> Other Health conditions not listed: _____ 	<ul style="list-style-type: none"> <input type="radio"/> Multiple sclerosis <input type="radio"/> Epilepsy or convulsions <input type="radio"/> HIV/Aids <input type="radio"/> History of sexually transmitted diseases <input type="radio"/> History of smoking # _____ day <input type="radio"/> History of smokeless tobacco use <input type="radio"/> History of alcohol abuse <input type="radio"/> History of recreational drug use <input type="radio"/> Other: _____
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Please circle the following as you feel are significant to you:

Muscle pain	Shoulder pain	Elbow pain
Knee pain	Low back pain	Neck pain
Other joint or muscular pain: _____	Sinus pain	
Migraine headache	Tension headache	Cluster headache
Cold/flu/bronchitis/pneumonia	Hay fever/allergies	Asthma
Nose bleeds frequently	Wheezing	Bad breath
Tongue sores	Lack of thirst	Dry mouth/throat
Poor or no appetite	Acid reflux	Nausea
Abdominal bloating	Indigestion	Abdominal pain/cramp
Hemorrhoids	Hard dry stools	Chronic loose stools/diarrhea
Bowel movement every _____ days		
Vertigo, dizziness	Ringling in ears	Palpitations/irregular heartbeat
Color blind	Dry eyes	Unusual hair loss
Eczema/acne/skin eruptions	Skin tags on neck	Fatty nodules under skin
Brittle nails	Edema/water retention	Motion sickness or seasickness
Difficulty gaining weight	Difficulty losing weight	
I get chilled easily	Cold hands and feet	Wear socks to sleep often
Cannot take a cold shower	My body is constantly hot	
I prefer the winter season	My body accepts more summer season	
Insomnia	Anxiety	Worry

Patient's initials: _____

Sleeping too much	Depression	Mental breakdown			
Nightsweats	ADD/ADHD	Nightmares			
How many hours do you sleep through the night? _____ hours					
Incontinence of urine	Frequent urination	Cloudy/bubbling urine			
Painful burning urination	Bladder or kidney stones	Urinate _____x night			
How often do you urinate during the day? Every hour Every 2 hours Every 3 hours Every 4 hours?					
When passing the bowel, does it most of the time feel complete_____ or often feel unrelieved? _____					
Do you enjoy meats? _____ or do you find them to be heavy and hardly digestible? _____					
Do you enjoy fried foods? _____ or do you find them to be heavy and hardly digestible? _____					
When I act or move, I sweat: A lot Little Almost never					
I usually sweat on my: Head Face Neck Back Upper body Arm pit Lower body Whole body Palm and sole					
Do you see yourself accomplishing tasks at the last moment? _____ or in a step by step increments? _____					
Are you highly sensitive to initially perceived criticisms? _____ or do you let them pass easily? _____					
I have a fear of or discomfort with: Heights Closed places Open places Insects					
History of childhood illness? _____ Bedwetting? _____					
Check any of the following that gives you a negative reaction:					
Caffeine	Milk/dairy	Wheat/gluten	Shellfish	Egg	Melon
Mango	Perfumes	Penicillin	Nickel in jewelry		
Dander/dust/pollen		Other: _____			
MEN:					
Potency issue		Prostatitis		Fertility difficulties	
WOMEN:					
Age when periods began: _____			Last PAP smear date: _____		
Duration of flow days: _____			Is you cycle regular? _____		
Date of the last period; _____			Do you believe you are pregnant? _____		

Patient's initials: _____

Difficulties during period:

Excessive flow Clots Breast distension Emotional changes Less flow

Menstrual cramps: Every or almost every period _____ Infrequent _____

Fertility difficulties? _____ If yes, how long? _____ Habitual miscarriage? _____

of pregnancies: _____ # of births: _____ # of abortions: _____

of miscarriages: _____ # of C-sections: _____

Birth control history, method & durations of use: _____

Breast cysts? _____ Low libido? _____ Menopausal symptoms? _____ Vaginal

yeast infections? _____ Endometriosis: _____ PCOS: _____

PAIN LOCATION & DESCRIPTION:

Use the diagram below to indicate types of pain/sensation using these symbols on the affected body area:

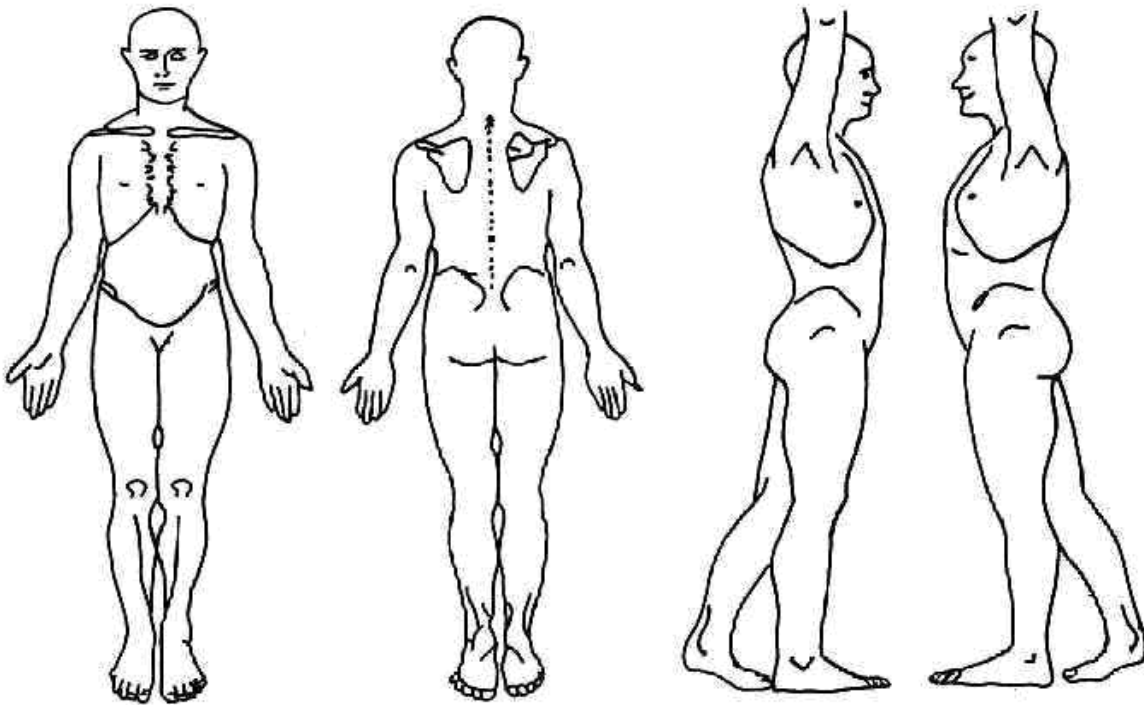
++++ Ache

ooooo Pins & needles

xxxxx Burning pain

///// Stabbing pain

>>>> Numbness



Patient's initials: _____

CONSENT FORM

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to: acupuncture, electro-acupuncture, facial rejuvenation acupuncture, cupping, herbal therapy, tuina, pricking, moxibustion, gua sha massage, infrared therapy, Reiki, sound therapy and nutritional counseling.

I understand that acupuncture, moxibustion, cupping, and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Organ damage from the needle is another extremely rare risk and I understand my practitioner is trained thoroughly to avoid this risk. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner’s recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse effects.

I understand that all information regarding my health and personal records will be kept confidential. By providing my email address on the intake form, I give consent to receiving email newsletters, I may unsubscribe at anytime.

I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgement in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24-hrs notice is required to reschedule or cancel an appointment and 48 hours notice is required if your appointment is on Monday. **Unless otherwise agreed to in advance, a \$50 service fee will be charged for the first missed appointment and the FULL appointment fee will be charged for all subsequent missed appointments without such advance notification.**

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment, and healthcare operations received, incurred or carried out at Janis Krause acupuncture and Chinese medicine office.

Print Patient Name & Patient Signature

Date

Patient’s initials: _____