CREEKSIDE PERFORMANCE CENTER

Acupuncture & Oriental Medicine Intake Form

Personal History

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Birth Date: _____ Age: _____ Sex: _____

Circle One: Married Widowed Divorced Separated Single

Occupation: _____

Referred To This Office by: _____

Name & Number of Emergency Contact: _____

Relationship: _____

Current Health Condition

Unwanted Health Condition: _____

Other Doctors Seen For This Condition: Yes No

(If yes, Dr. Name: _____)

Type of Treatment: _____

Results: _____

When Did This Condition Begin: _____

Drugs You Now Take (circle): Pain Killers Muscle Relaxants

Blood Pressure Medicine Weight Loss Pills Insulin

Other: _____

Past Health History

Major Surgery/Operations (circle): Back Surgery Neck Surgery

Broken Bones Appendectomy Gall Bladder Hernia

Other: _____

Major Accidents or Falls: _____

Hospitalizations: _____

Previous Acupuncture Care: Yes No

Previous Massage Care: Yes No

Acupuncturist's Name & Approximate Date of Last Visit:

_____

Confidential Patient Health Record

Circle All That Apply:

Family History

Asthma	Diabetes	Kidney Disease	Obesity
Arthritis	Eczema	Leukemia	Rheumatism
Allergies	Epilepsy	Back pain	Stroke
Anemia	Goiter	Measles	Suicide
Alcoholism	High Blood Pressure	Mental Disorder	Thyroid Issues
Cancer	Heart Disease	Migraine	

Comments:

_____

_____

_____

_____

Circle any of the following you've had in the **Last 6 Months:**

Musculoskeletal

Low Back Pain
Pain Between Shoulders
Neck Pain
Arm Pain
Joint Pain/ Stiffness
Walking Problems
TMJ
General Stiffness
Tendonitis

Nervous System

Nervous
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/ Depression
Fainting
Convulsions
Cold/ Tingling Extremities
Stress

Female Only

Menstrual Cramps
Menstrual Blood Clots
Excessive Bleeding
PMS
Breast Swelling
Breast Pain
Hot Flashes
Vaginal Yeast Infections

General

Fatigue
Allergies
Loss of Sleep
Fever
Headaches/ Migraines

Genitourinary

Bladder Trouble
Painful Urination
Discolored Urine

CVR

Chest Pain
Shortness of Breath
Blood Pressure Problems
Irregular Heartbeat
Lung Problems
Varicose Veins
Ankle Swelling
Stroke

Chinese Medicine

Are you a cold person?
Sweat Easily
Anger Easily
Have Brittle Nails
Have Floaters in Vision
Have Tinnitus

ENT

Vision Problems
Dental Problems
Sore Throat
Ear Aches
Hearing Difficulty
Stuffed Nose

Gastrointestinal

Poor/ Excessive Appetite
Excessive Thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Heartburn
Liver Problems
Gall Bladder Problems
Weight Trouble
Abdominal Cramps

Men Only

Impotence
Prostate Problems
Infertility

Medications, Herbal, and Other Supplements

Patient Name:_____ Date:_____

Are you currently taking any of the following medications?

Yes	No	**Analgesics** (Aspirin, Ibuprofen, Naproxen Sodium)	Dosage_____	Frequency_____
Yes	No	**Antacids** (Bicarbonate of Soda, Calcium Carbonate)	Dosage_____	Frequency_____
Yes	No	**Antibiotics**	Dosage_____	Frequency_____
Yes	No	**Anti-Inflammatories** (Prednisone, other corticosteroids, NSAIDs)	Dosage_____	Frequency_____
Yes	No	**Birth Control Pills**	Dosage_____	Frequency_____
Yes	No	**Blood Pressure Pills**	Dosage_____	Frequency_____
Yes	No	**Blood-thinning Pills**	Dosage_____	Frequency_____
Yes	No	**Cardiovascular Agents** (Digoxin, Lanoxin, Captopril)	Dosage_____	Frequency_____
Yes	No	**Diuretics** (Lasix)	Dosage_____	Frequency_____
Yes	No	**Elixirs containing sorbitol**	Dosage_____	Frequency_____
Yes	No	**Insulin or Diabetic Pills**	Dosage_____	Frequency_____
Yes	No	**Laxatives**	Dosage_____	Frequency_____
Yes	No	**Respiratory Agents** (Theophylline)	Dosage_____	Frequency_____
Yes	No	**Sedative, Antianxiety, Antipsychotic Drugs** (Lithium, Thioridazine, Chlorpromazine, Prozac)	Dosage_____	Frequency_____
Yes	No	**Seizure Medication**	Dosage_____	Frequency_____
Yes	No	**Sleeping Pills**	Dosage_____	Frequency_____
Yes	No	**Thyroid Medication**	Dosage_____	Frequency_____
Yes	No	**Weight Reducing Pills**	Dosage_____	Frequency_____

List any other including over the counter medications you currently take/use:_____

_____

Please list any herbal or other natural supplements, vitamins, & minerals you're taking:_____

_____

Are you allergic to any medications, natural supplements, or over the counter meds. Please name & describe reaction:_____

Acupuncture Information and Informed Consent

Acupuncture is performed by the insertion of Pre-Sterilized, Disposable acupuncture needles through the skin, and/or the application of heat or electrical stimulation to the skin, or both, at certain points on the body. The benefits and risks of receiving acupuncture and Oriental Medical treatment have been explained to me. Although rare, certain side effects may result from Acupuncture, I understand that each procedure or treatment has specific risks and benefits. I understand that licensed Acupuncturists perform these treatments. I understand that Fresh Hope Healing Center may record medical and other information concerning my treatment in electronic and in other physical form. Such information may be released by the clinic for the purpose authorized on this form. I understand that portions of my medical records may be disclosed to qualified non- clinic personnel for the purpose of conducting scientific or statistical research, management, or financial audits, licensure and program evaluation without my express consent. I understand that the practice of Acupuncture and Oriental Medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or examination at Creekside Performance Center. I have been informed of the risk and benefits of the procedures and products listed below that apply to my treatment:

Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points. The use of mechanical, magnetic or electrical stimulation of acupuncture points, particularly in instances where such stimulation is applied across the midline of the trunk or in patients with a history of heart trouble, moxabustion, herbs, acupressure, massage, and nutrition and food therapies.

I have been informed and understand the risks and side effects listed: 1)Minor bruising, 2)Needle sickness, 3)Broken needles, 4)some pain at the site of needle insertion, 5)Infection, 6)the risks of needling in the vicinity of an infection, and 7)potential side effects of nutritional supplements and herbs.

Record Release Authorization I understand that I am responsible for my bill. I authorize payment directly to my clinician. I authorize the use of this form for all of my insurance submissions I authorize release of information to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I direct my previous health care providers to release medical records to this clinic I authorize my clinician to act as my agent to obtain payment from my insurance companies (for charged services). This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State of Federal Law.

Patient's Signature_____ Date_____
Witness Signature_____ Date_____

Consent to Treat a Minor Child

I authorize _____ and whomever he/she designates as assistants to administer Acupuncture and Oriental Medicine care as deemed necessary to my _____ (relationship)

Patients Name
_____ Adult's Signature _____ Date_____