ACUPUNCTURE ATLANTA
INTAKE FORM

Name:____ Today's Date:_______________________

Name of Parent/Guardian (if under 18):____

Address:____

City: ___________________________________ State: ______________________ Zip:_____________________

Primary Phone: (________)__________-____________ Email:____

Birthdate: _____________________________________ Sex: ___Female ___Male

Relationship Status: ___Single ___Married ___Domestic Partnership ___Divorced ___Widowed ___Other

Occupation: ____________________________________ Employer: ____

Referred by (if any): ____

Emergency Contact Information:

Name:____

Primary Phone: (________)________-___________ Alternate Phone: (______)________-___________

Relation to you: _________________________________

Briefly describe your present health concerns and/or areas of distress:

Physical: ____

Emotional: ____

Emotional: ____

Other Concerns: ____

Current Medications: (both prescription and non) ____

____

Have you ever been tested for HIV? ___Yes ___No

Results? ___Positive ___Negative

Do you have any surgical implants? ___Yes ___No

What kind? _____________________________

List any current therapies or treatments:

Start Date:	Therapies or Treatment Modality:	City & State

List any healthcare providers you have consulted in the past 3 years:

Name:	Field/Specialty:

MEDICAL HISTORY

Please Check any of the following symptoms you currently or have previously experienced:

VERY IMPORTANT INFORMATION

__Pacemaker __Metal Support __Infectious Disease

Musculoskeletal & Nervous System

__Sore Muscles __Aching muscles __Weak muscles __Tight muscles __Muscle Cramps
__Muscle jerking __Bursitis __Arthritis __Scoliosis __Headaches
__Migraine Headaches __Numbness/tingling __Paralysis __Convulsions/Seizures __Head Injury
__Recently knocked Unconscious

Broken bones:____

Bone or joint disease:____

Recurrent dislocations:____

Other Injuries:____

Digestive System and Abdomen

__Poor appetite __Excessive appetite __Irregular appetite __Change in eating habits
__Change in appetite __Nausea __Abdominal pain __Indigestion
__Heartburn __ "Nervous stomach" __Ulcers __Vomiting: Food Blood Bile
__Black stool __Bloody stool __Fatty Stool __Change in gas / belching
__Diarrhea __Constipation __Hemorrhoids __Bleeding hemorrhoids
__Hemorrhoids-piles __Rectal bleeding __Parasites __Worms
__Hepatitis __Liver problems __Gallbladder problems __Pancreas problems
__Ulcers __Hernia: Abdominal Inguinal Hiatal

Heart and Circulation

__Chest pain __Rapid heart beat __Slow heart beat __Irregular heart beat __Pain over heart
__High blood pressure __Low blood pressure __Varicose veins __Swelling/edema __Ankle swelling
__Hand swelling __Pain in calf while walking

Other heart problems: ____

Skin, Hair & Nails

__Itchy skin __Sensitive skin __Rash __Bruise easily
__Excessive perspiration __Deficient perspiration __Premature gray hair

Nail problems: ____

Other hair/scalp problems:____

Reproductive System

__Vaginal discharge __Vaginal pain __Abnormal Vaginal bleeding __Breast tenderness
__Breast lumps __Breast discharge __Menstrual related mood changes __Menstrual cramps
__Menopause problems __Hot flashes __Menstrual flow: Heavy Medium Light
__Genital lesions __Hernia __Testicular mass or lump __Testicular pain
__Prostate problems __Erectile problems __Ejaculation problems

Length of menstrual cycle (start to start days):_____________________ Date of last period (1st day)________________

Number of pregnancies:___________ Number of Children:__________

Reproductive System (continued)

Birth control method:____

Sexual difficulties:____

Kidney & Bladder

__Painful urination	__Blood in urine	__Frequent urination	__Urgent urination
__Difficult urination	__Lack of bladder control	__Wake to urinate	__Bedwetting
__Excessive urine	__Scanty urine	__Strong odor in urine	__Discolored urine
__Urethral discharge	__Urinary infection	__Kidney stones	__Intermittent urination

Other related problems:____

Respiratory System

__Difficulty breathing	__Painful breathing	__Persistent cough	__Coughing of phlegm
__Coughing of blood	__Hyperventilation	__Asthma/wheezing at night	__Chronis sinus congestion
__Infrequent sinus congestion	__Asthma/wheezing on exertion	__Shortness of breath on exertion	__Shortness of breath at night

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Eye, Ear, Nose, Throat & Mouth

__Eye strain	__Eye inflammation	__Blurred vision	__Ear pain	__Ringing in ears
__Ear discharge	__Loss of hearing	__Loss of sight	__Loss of taste	__Loss of smell
__Nose pain	__Nose bleeding	__Nose discharge	__Sore throat	__Hoarseness
__Difficulty swallowing	__Difficulty w/ speech	__Difficulty w/ chewing	__Teeth problems	__Gum problems
__Mouth ulcers	__Bad taste in mouth	__Excessive saliva	__Deficient saliva	

__Difficulty breathing from nose during day __Difficulty breathing through nose at night

Other vision problems:____

Tongue Problems:____

Miscellaneous

__Thyroid problems: Hypo or Hyper __Rapid weight gain __Rapid weight loss __Heat & cold intolerance

__Cold hands and feet	__Excessive thirst	__Slow to heal	__Enlarged glands	__Water retention
__Tire easily	__General fatigue	__Poor memory	__Dizziness	__Fainting
__Fever	__Chills	__Night sweats	__Shaky feelings	__Confusion
__Irritability	__Depression	__Anxiety	__Emotional breakdown	__Cry easily
__Anemia	__Dehydration	__Difficulty concentrating		

Indicate if you have been diagnosed with any of the following:

__Cancer	__Diabetes	__Hypoglycemia	__STD
__Mononucleosis	__HIV/AIDS	__CMV	__Epstein-Barr

Allergies (food and other):____

____

Favorite foods: ____

Significant medical history (illnesses, surgeries, injuries) birth to present not yet mentioned:

____

____

____

Current weight: _____________ Weight 1 year ago:____________

Max weight: ___________date:________________

Indicate if you have ever had surgery involving any of the following:

__Appendix __Gallbladder

__Ovary(ies) __Uterus Other surgeries:____________________________________

Have you ever had a blood transfusion? Yes No Type: __Blood __Plasma Year:____________

Indicate if you have ever had x-rays done on any of the following:

	Yes	No
Back	___	___
Neck	___	___
Extremities	___	___
Chest	___	___
Gallbladder	___	___
Colon	___	___
Stomach	___	___

Other x-rays: __________________________

Have you ever had a CT scan? Yes No Have you ever had an MRI? Yes No

Personal Habits

Yes	No	
___	___	Do you sleep well? Hours of sleep per night: _____
___	___	Awaken Rested?
___	___	Do you have regular bowel movements?
___	___	Sex satisfactory?
___	___	Do you like your work?
___	___	Do you watch tv? Hours watched per day:______
___	___	Do you participate in sports/hobbies for at least 3 hrs. per week?
___	___	Do you exercise? Describe your exercise:____

Yes	No	
___	___	Do you read? Hours read per day: _____
___	___	Do you take vacations?
_____		Weeks of vacation per year
___	___	Have you been treated for alcoholism?
___	___	Have you been treated for drug abuse?

____

____

What types of stress are you under?____

What do you do to relieve stress?____

How often do you use the following?

	Never	Occasionally	Frequently
Vitamins	___	___	___
Sedatives/Tranquilizers	___	___	___
Laxatives	___	___	___
Aspirin, etc.	___	___	___
Appetite Suppressant	___	___	___
Sleeping Pills	___	___	___
Coffee/Tea	___	___	___
Cups per day	_________		

	Never	Occasionally	Frequently
Alcoholic Beverages	___	___	___
Recreational Drugs	___	___	___
Cigar or Pipe	___	___	___
Chewing Tobacco/Snuff	___	___	___
Marijuana	___	___	___
Soft Drinks	___	___	___
Cigarettes	___	___	___
Packs per day:	_________		

Briefly describe other significant health problems and concerns not listed on this questionnaire:

____

____

Family History

For your mother, father, siblings, children and spouse, check applicable illnesses:

	Mother	Father	Sister	Brother	Children	Spouse
Tuberculosis	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___
Heart Trouble	___	___	___	___	___	___
High Blood Pressure	___	___	___	___	___	___
Stroke	___	___	___	___	___	___
Epilepsy	___	___	___	___	___	___
Emotional Crisis	___	___	___	___	___	___
Asthma, Hives, Hay Fever	___	___	___	___	___	___
Cancer	___	___	___	___	___	___
Type of Cancer:						
Death	___	___	___	___	___	___
Year:						
Cause:						

ACUPUNCTURE ATLANTA

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

Dear Valued Patient:

This informed consent sheet is a requirement of the State of Georgia under Chapter 360-6.

This is to inform you that an acupuncturist is not licensed to practice medicine in the State of Georgia; an acupuncturist is not making a medical diagnosis of your disease or medical condition; if you want to obtain a medical diagnosis you should see a licensed physician and seek medical advice.

The acupuncturist will explain to you the nature and purpose of the acupuncture treatment being rendered.

This is your personal agreement to acknowledge these statements.

________________________________ ______________________________

Print Name Signature

____

Date

ACUPUNCTURE ATLANTA

24 HOUR CANCELLATION POLICY

Acupuncture Atlanta has a 24 hour cancellation/ rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $45.

This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Acupuncture Atlanta as described above.

Thank you for your understanding and cooperation.

________________________________ ________________________________

Print Name Signature

____

Date