

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Lack of bladder control | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Excessive urine | <input type="checkbox"/> Scanty urine | <input type="checkbox"/> Strong odor in urine | <input type="checkbox"/> Discolored urine |
| <input type="checkbox"/> Urethral discharge | <input type="checkbox"/> Urinary infection | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Intermittent urination |

Other related problems: _____

Respiratory System

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Painful breathing | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Coughing of phlegm |
| <input type="checkbox"/> Coughing of blood | <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Asthma/wheezing at night | <input type="checkbox"/> Chronis sinus congestion |
| <input type="checkbox"/> Infrequent sinus congestion | <input type="checkbox"/> Asthma/wheezing on exertion | <input type="checkbox"/> Shortness of breath on exertion | <input type="checkbox"/> Shortness of breath at night |

Eye, Ear, Nose, Throat & Mouth

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye inflammation | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Loss of sight | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Nose pain | <input type="checkbox"/> Nose bleeding | <input type="checkbox"/> Nose discharge | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Difficulty w/ speech | <input type="checkbox"/> Difficulty w/ chewing | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Mouth ulcers | <input type="checkbox"/> Bad taste in mouth | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Deficient saliva | |
| <input type="checkbox"/> Difficulty breathing from nose during day | <input type="checkbox"/> Difficulty breathing through nose at night | | | |

Other vision problems: _____

Tongue Problems: _____

Miscellaneous

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Thyroid problems: Hypo or Hyper | <input type="checkbox"/> Rapid weight gain | <input type="checkbox"/> Rapid weight loss | <input type="checkbox"/> Heat & cold intolerance |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Slow to heal | <input type="checkbox"/> Enlarged glands |
| <input type="checkbox"/> Tire easily | <input type="checkbox"/> General fatigue | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Shaky feelings |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emotional breakdown |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dehydration | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Confusion |
| | | | <input type="checkbox"/> Fainting |
| | | | <input type="checkbox"/> Cry easily |

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

- | | | | |
|--|-----------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> STD |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> CMV | <input type="checkbox"/> 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:

	<u>Yes</u>	<u>No</u>
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

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
___	___	Do you sleep well? Hours of sleep per night: _____	___	___	Do you read? Hours read per day: _____
___	___	Awaken Rested?	___	___	Do you take vacations?
___	___	Do you have regular bowel movements?	___	___	Weeks of vacation per year
___	___	Sex satisfactory?	___	___	Have you been treated for alcoholism?
___	___	Do you like your work?	___	___	Have you been treated for drug abuse?
___	___	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: _____			

What types of stress are you under? _____

What do you do to relieve stress? _____

How often do you use the following?

	Never	Occasionally	Frequently		Never	Occasionally	Frequently
Vitamins	___	___	___	Alcoholic Beverages	___	___	___
Sedatives/Tranquilizers	___	___	___	Recreational Drugs	___	___	___
Laxatives	___	___	___	Cigar or Pipe	___	___	___
Aspirin, etc.	___	___	___	Chewing Tobacco/Snuff	___	___	___
Appetite Suppressant	___	___	___	Marijuana	___	___	___
Sleeping Pills	___	___	___	Soft Drinks	___	___	___
Coffee/Tea	___	___	___	Cigarettes	___	___	___
Cups per day	_____			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
<u>Tuberculosis</u>	___	___	___	___	___	___
<u>Diabetes</u>	___	___	___	___	___	___
<u>Heart Trouble</u>	___	___	___	___	___	___
<u>High Blood Pressure</u>	___	___	___	___	___	___
<u>Stroke</u>	___	___	___	___	___	___
<u>Epilepsy</u>	___	___	___	___	___	___
<u>Emotional Crisis</u>	___	___	___	___	___	___
<u>Asthma, Hives, Hay Fever</u>	___	___	___	___	___	___
<u>Cancer</u>	___	___	___	___	___	___
Type of Cancer:						
<u>Death</u>	___	___	___	___	___	___
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

WAIVER OF LIABILITY RELATING TO COVID 19/CORONAVIRUS

Please read carefully:

Acupuncture Atlanta cannot prevent you [or your child(ren)] from becoming exposed to, contracting, or spreading COVID-19 while utilizing [Acupuncture Atlanta]'s services or premises. It is not possible to prevent against the presence of the disease. Therefore, if you choose to utilize Acupuncture Atlanta's services and/or enter onto Acupuncture Atlanta's premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself and/or my children in order to utilize Acupuncture Atlanta's services and enter Acupuncture Atlanta's premises. These services are of such value to me [and/or to my children,] that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to utilize Acupuncture Atlanta's services and premises in person.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against Acupuncture Atlanta and its owners, independent contractors, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to utilizing Acupuncture Atlanta's services and premises. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

CHOICE OF LAW: I understand and agree that the law of the State of **Georgia** will apply to this contract.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE:

Signature: _____ Date: _____

Name (printed): _____

I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release.

Signature : _____ Date: _____

Name (printed) _____