Acupuncture Patient Intake

Patient Personal Information

Name_____ Date_____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Occupation_____ Email_____

Sex: M/F Height_____ Weight_____ Birth Date_____ Age_____

Marital Status: Married / Single / Divorced / Widowed Number of Children_____

Have you received acupuncture therapy before? Yes / No

When? _____ With whom? _____

Please Indicate (check off) any significant illnesses you or a blood relative have had.

Illness	You	Your relative	Approx. Date
Cancer	____	____	____
Hepatitis	____	____	____
High Blood Pressure	____	____	____
Rheumatic Fever	____	____	____
Infectious Diseases	____	____	____
Diabetes	____	____	____
Heart Disease	____	____	____
Seizures	____	____	____
Emotional Disorders	____	____	____
Tuberculosis	____	____	____

Sexually transmitted diseases: (circle) Gonorrhea / Syphilis / HIV / HPV / Herpes / Date: _____

List any medications or supplements you are currently taking: (continue on back if necessary)

Medicine: Dosage: Reason: How long: Prescribed by: Last checkup:

Please indicate the use and frequency of the following:

Coffee: Yes___ No___ How much? _____

Non-medical drugs: Yes___ No___ How much? _____

Tobacco: Yes___ No___ How much? _____

Alcohol: Yes___ No___ How much? _____

Water intake: Yes___ No___ How much? _____

Soda: Yes___ No___ How much? _____

What are the main health concerns for which you are seeking treatment?

_____

_____

What other forms of treatment have you sought?

_____

_____

List any allergies, food sensitivities or food cravings that you have.

_____

_____

List any accidents, surgeries or hospitalizations (include dates).

_____

_____

Lab results (include copies if appropriate).

_____

_____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments:
Significant other:	____	____	____	____	____	_____
Family:	____	____	____	____	____	_____
Diet:	____	____	____	____	____	_____
Sex:	____	____	____	____	____	_____
Work:	____	____	____	____	____	_____
Exercise:	____	____	____	____	____	_____
Spirituality:	____	____	____	____	____	_____

FOR WOMEN

Age of 1st period (menarche): _____ Are you pregnant? Yes ____ No ____ # of pregnancies? ____

Age of last period (menopause): _____ # of live births: ____ # of abortions: ____ miscarriages: _____

Number of days between periods: _____ Date of last gynecological exam: _____ PAP smear: _____

Mammogram: _____ Results: _____ Bone density scan: _____ Results: _____

Color of menstrual flow: _____ Clots? Yes ____ No ____ Color of clots: _____

Average # of pads / tampons you use per day: 1st day ____ 2nd day ____ 3rd day ____ 4th day ____ + days ____

Have you been diagnosed with: Fibroids ____ Fibrocystic breasts ____ Endometriosis ____

Ovarian cysts ____ PID ____ Other: _____

Location of menstrual pain: Lower abdomen ____ Lower back ____ Thighs ____ Other _____

Nature of pain (please indicate before, during or after menses)

Cramping ____ Stabbing ____ Burning ____ Aching ____ Dull ____ Bloating ____ Consistent ____

Intermittent ____ Bearing down sensation ____

Other symptoms related to menses: Discharge ____ Nausea ____ Swollen breasts ____ Poor appetite ____

Increased libido ____ Decreased libido ____ Vaginal dryness ____ Constipation ____ Mood swings ____

Hot flashes ____ Headache ____ Diarrhea ____ Ravenous appetite ____ Night sweats ____ Insomnia ____

FOR MEN

Date of last prostate exam: _____ PSA result:_____ Manual prostate exam result: _____

Lab result: _____

Frequency of urination: Daytime ____ Nighttime ____ Color: Clear ____ Murky ____ Odor: ____

Symptoms related to prostate:

Delayed stream: ____ Dribbling: ____ Incontinence: ____ Retention of urine: ____ Rectal dysfunction: ____

Increased libido: ____ Decreased libido: ____ Premature ejaculation: ____ Impotence (E.D.): ____ Back pain: ____

Groin pain: ____ Testicular pain: ____ Other: _____

SYMPTOM SURVEY (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
No mark ( ) = never experience Check mark (√) = sometimes experience Plus sign (+) = frequently experience

(EA)
___lack of appetite
___excessive appetite
___loose stool/diarrhea
___indigestion
___vomiting
___belching/burping
___heartburn/reflux
___food retention
___obsessive in work/relationships
___fatigue
___edema
___blood in stool
___black or tarry stool
___bruising
___difficult to stop bleeding
___catch colds easily
___weather change intolerance
___dizziness
___fainting
___high cholesterol
___sudden weight loss
___abdominal pain
___hemorrhoids

(FI)
___nightmares
___insomnia
___palpitations
___cold hands/feet
___mentally restless

(MT)
___cough
___shortness of breath
___decreased sense of smell
___nasal/sinus problems
___skin problems
___claustrophobia
___bronchitis
___colitis/diverticulitis
___constipation
___recent use of antibiotics
___asthma
___allergies/hay fever
___catch colds easily
___intolerant to weather changes

(WD)
___eye problems
___jaundice
___difficulty digesting oils
___gallstones
___light colored stool
___soft/brittle nails
___easily angered/agitated

___difficulty making decisions
___spasms/twitching muscles
___sighing
___timidity
___easily startled

(WA)
___low back pain
___knee problems
___hearing impaired
___tinnitus (ear ringing)
___kidney stones
___low sex drive
___hair loss
___decreased urinary flow
___impotence (ED)
___frequent urination
___nocturia (night urination)
___feeling cold
___scanty dark urine
___night sweating
___difficult/painful urination
___turbid urine
___genital itch
___urethral discharge
___genital rash
___dizziness
___blurred vision
___depression
___pain in testes/perenium
___premature graying hair
___abnormal sperm
___urethral discharge
___premature ejaculation
___burning palms/feet
___low sperm count

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

While Oriental Medicine (acupuncture, etc.) has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently it is recommended that you consult a physician regarding any condition(s) for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211.1(b) of NYS Education law, we request that you read and sign the following statement:

WE THE UNDERSIGNED, DO AFFIRM THAT_____ (Patient) HAS BEEN ADVISED BY: **Robert Giordano L.Ac.** TO CONSULT A PHYSICIAN REGARDING THE CONDITION(S) FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ _____
Patient Signature Date

_____ _____
Licensed Acupuncturist Signature Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Robert Giordano L.Ac. I have discussed the nature and purpose of my treatment with this acupuncturist. I understand that methods of treatment may include but are not limited to: acupuncture, cupping, electrical stimulation and Tui Na (Chinese massage). I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this practitioner uses only sterile, disposable needles and maintains a clean and safe environment to minimize this risk. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources), which may be recommended, are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Robert Giordano, L.Ac., if there are any unpleasant effects associated with the consumption of the herbal teas. I will notify Robert Giordano, L.Ac., if I am or become pregnant. I do not expect Robert Giordano, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment and I wish to rely on his professional judgment during the course of treatment which Robert Giordano, L.Ac., thinks at the time, based upon the facts known to him, is in my best interest. I understand that my records will be kept confidential and will not be released to any party without my written consent.

III. CANCELLATION POLICY

Robert Giordano L.Ac.(GIORDANO ACUPUNCTURE) maintains a **12 hour** cancellation policy. If you feel the need to cancel or re-schedule your appointment please do so within the 12 hour period to avoid cancellation fees.

_____
Date consent Completed

_____
Print Name of Patient

_____
Signature of Patient or Representative

_____
Print Name of Patient Representative