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? _____

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):

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

Patient's initials: _____

o Mental disorder o Gout o Hepatitis o Liver cirrhosis o Gall stones o Jaundice o Hernia o Other Health conditions not listed: _____	o Multiple sclerosis o Epilepsy or convulsions o HIV/Aids o History of sexually transmitted diseases o History of smoking # _____ day o History of smokeless tobacco use o History of alcohol abuse o History of recreational drug use o Other: _____

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	Ringing 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: _____

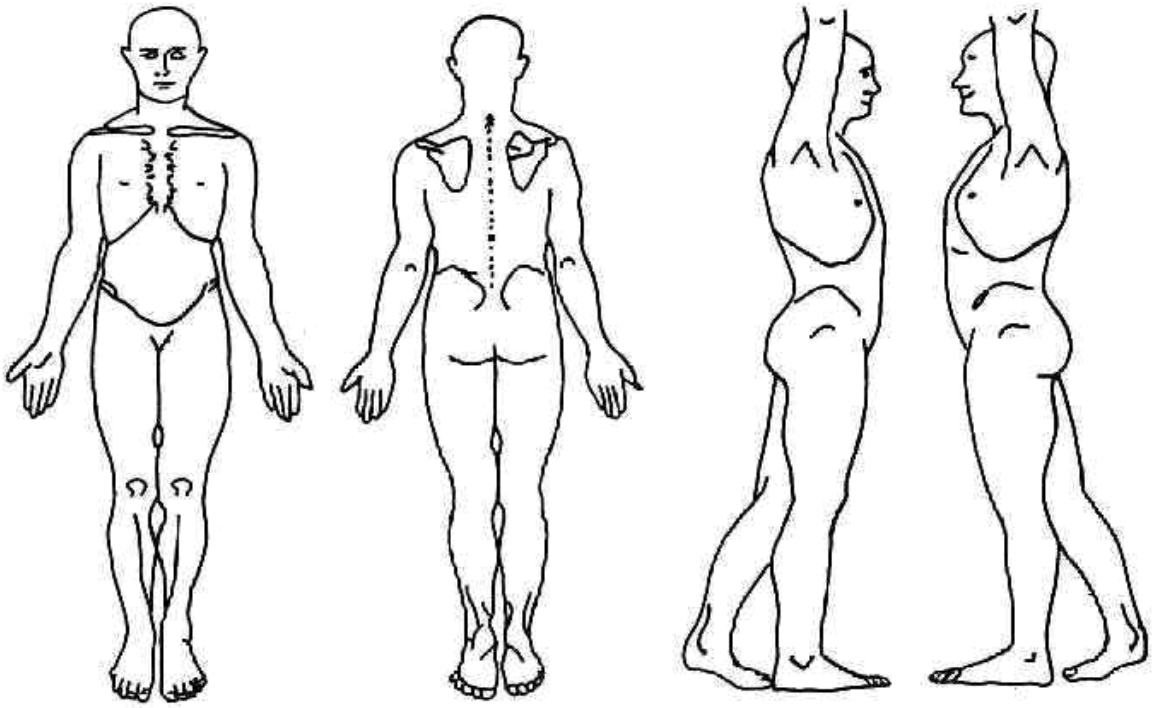
Breast cysts? _____Low libido? _____ Menopausal symptoms? _____ Vaginal yeast infections? _____ Endometriosis:_____ PCOS:_____

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, body talk, sound therapy, lympathtic drainage (VMLD) 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 20-hrs notice is required to reschedule or cancel an appointment and 48 hours notice is required if your appointment is on a 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: _____