newbeginnings chiropractic

ACUPUNCTURE

PATIENT INFORMATION

Welcome! During your first visit or consultation, I hope to come to understand your health concerns, answer questions you may have and give you an examination or consultation using the alternative medicine approach. Then we will review the results together and look at your options and available forms of treatment. If you elect to undertake treatment, we may begin as soon as possible. Treatment often begins at one's first visit. Your treatment with me is meant to compliment and not replace your regular visits to your Primary Care Practitioner.

This is a CONFIDENTIAL questionnaire to help me determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you!

Personal Information

Name_____ Age_____ Date of Birth _____

Home Address_____

City_____ State_____ Zip _____

Cell Phone_____Home Phone_____Email_____

DOB:_____ If under 18, person responsible for your account_____

Emergency Contact: Name_____ Contact Phone_____

Whom should I thank for referring you to me? _____

Have you had acupuncture therapy before? □ Yes □ No With whom?_____

Please indicate if any of the following pertain to you: (checking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds

□ Pregnancy (certain or possible)

Please indicate the use and frequency of the following:

Coffee _____ Soda pop_____ Water_____

Alcohol_____ Recreational drugs _____ Tobacco_____

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason

Health History

What are the health problems for which you are seeking treatment?

_____

_____

How long have you had this condition?

_____

What other forms of treatment have you sought?

_____

_____

What helps your condition?

_____

What aggravates your condition?

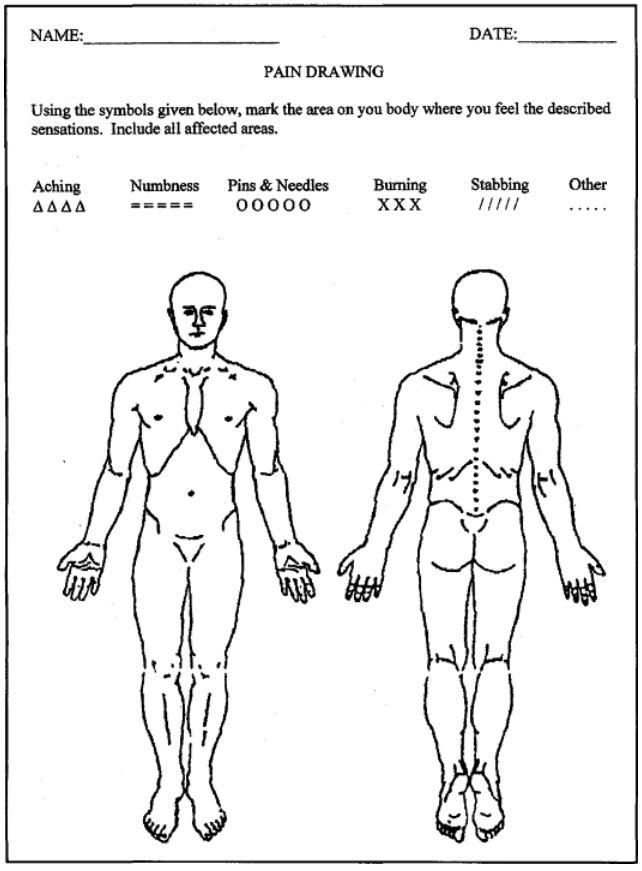
_____

Please list any surgeries or major health incidents (accidents, hospital procedures, etc.) in your life:

_____

_____

Pain History: If you've experienced ANY pain within the past 6 months please indicate in the diagram below



ACUPUNCTURE ASSESSMENT

What would you like to achieve with your ***acupuncture*** treatment?

_____

_____

Please "check" the symptoms or conditions you experience frequently:

Sp/St	**Ht/P**	**Lu/LI**	**Ki/UB**	**Liv/GB**
□ excessive appetite	□insomnia	□cough	□low back pain	□eye problems
□ loose stool/diarrhea	□palpitations	□shortness of breath	□knee problems	□jaundice
□ digestive problems, indigestion	□cold hands and feet	□decreased sense of smell	□hearing impairment	□difficulty digesting oily foods
□ vomiting	□nightmares	□nasal problems	□ear ringing	□gall stones
□ belching, burping	□mentally restless	□skin problems	□kidney stones	□light-colored stool
□ heartburn/reflux	□laughing for no reason	□claustrophobia	□decreased sex drive	□soft or brittle nails
□ stomach bloating	□chest pains	□colitis/diverticulitis	□hair loss	□easily angered
□ obsession in work,	□poor memory	□constipation	□urinary problems	□difficult relationship
□ blood in stool	□sadness	□allergies	□dental problems	□difficulty making decisions
□ lack of appetite	□Depression	□asthma	□fatigue	□dizziness
□ hemorrhoids	□Anxiety	□get sick easily	□edema	□headaches
□easily bruised				
□ I usually feel warm	□I usually feel chilled			

Conclusion

Are you interested in additional health services besides acupuncture? □ No □ Yes

Please check which services you might be interested in:

□ Chiropractic Services □ Chinese herbal medicine □ Therapeutic massage □ Assisted Stretching/myofascial release

□ Relaxation techniques □ Nutritional consultation

Other:_____

Please indicate if the following pertain to you:
NOTE: This Symbol ♀: before a question, indicates that it is for Women only.

Kidney Yin Xu-
□ Do you have lower back weakness, soreness or pain?
□ Do you have ringing in your ears?
□ Is your hair prematurely gray?
□ Do you have dark circles under your eyes?
□ Do you have night sweats?
□ Are you prone to hot flashes?
□ Would you describe yourself as "afraid" frequently?
□ Do you have dizziness?
□ Do you have knee problems?
□ ♀**:** Do you have vaginal dryness?
□ ♀**:** Is your mid-cycle cervical mucus scanty or missing?

Kid Yang Xu-
□ Is your back sore or weak?
□ Are your feet cold, especially at night?
□ Are you typically colder than those around you?
□ Is your libido low?
□ Are you often fearful?
□ Do you wake up at night or early in the morning because you have to urinate?
□ Do you urinate frequently, and is the urine diluted and/or profuse?
□ Do you have early morning loose, urgent stools?
□ ♀**:** Do you have low back pain pre-menstrually?
□ ♀**:** Do you have profuse vaginal discharge?
□ ♀**:** Do you feel cold cramps during your period that respond to a heating pad?

Spleen Qi – Xue – Yang Xu
□ Are you often fatigued?
□ Do you have poor appetite?
□ Is your energy low after a meal?
□ Do you feel bloated after eating?
□ Do you crave sweets?
□ Do you have loose stools, abdominal pain, or digestive problems?
□ Are your hands and feet cold?
□ Are you prone to feeling sluggish?
□ Are you prone to heaviness or grogginess in the head?
□ Do you have varicose veins?
□ Are you prone to worry?
□ Have you been diagnosed with low blood pressure?
□ Do you sweat a lot without exerting yourself?
□ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
□ Are you often sick, or do you have allergies?
□ Have you ever been diagnosed with hypothyroid or anemia?
□ Do you have hemorrhoids or polyps?
□ ♀**:** Is your menstruation thin, watery, profuse, or pinkish in color?
□ ♀**:** Are you more tired around ovulation or menstruation?
□ ♀**:** Do you ever spot a few days or more before your period comes?
□ ♀**:** Have you ever been diagnosed with uterine prolapse?
□ ♀**:** Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

Blood Xu-
□ Do you have dry, flaky skin?
□ Are you prone to getting chapped lips?
□ Are your fingernails or toenails brittle?
□ Is your hair brittle or dry?
□ Do you have diminished nighttime vision?
□ Are your lips, the inner side of your lower eyelids, or tongue pale in color?
□ ♀**:** Do you get dizzy or light-headed around your period?

□ ♀**:** Are you losing hair on your head?
□ ♀**:** Are your menses scant or late?

Blood Stasis

□ Do you experience periodic numbness of your hands and feet, especially at night?
□ Do you have varicose or spider veins?
□ Do you have red cherry spots (hemangiomas) on your skin?
□ Do you have chronic hemorrhoids?
□ Do you have dark spots in your eyes?
□ Have you been diagnosed with any vascular abnormality or blood clotting disorder?
□ ♀**:** Does your menstrual blood contain clots?
□ ♀**:** Have you been diagnosed with endometriosis or uterine fibroids?
□ ♀**:** Do you have piercing or stabbing menstrual cramps?
□ ♀**:** your menstrual flow ever brown or black in color?
□ ♀**:** Do you feel mid-cycle pain around your ovaries?
□ ♀**:** Do you have painful, unmovable breast lumps?

Liver Qi Stagnation

□ Are you prone to emotional depression?
□ Are you prone to anger and/or rage?
□ Are your pupils usually dilated and large?
□ Do you have difficulty falling asleep at night?
□ Do you experience heartburn or wake up with a bitter taste in your mouth
□ ♀**:** Do you become irritable pre-menstrually?
□ ♀**:** Do you feel bloated or irritable around ovulation?
□ ♀**:** Does it feel as if your ovulation lasts longer than it should?
□ ♀**:** Are your breasts sensitive/sore at ovulation?
□ ♀**:** Do you experience nipple pain or discharge from your nipples?
□ ♀**:** Do you have a lot of pre-menstrual breast distension or pain?
□ ♀**:** Do you become bloated pre-menstrually?
□ ♀**:** Are your menses painful?
□ ♀**:** Do you feel your menstrual cramps in the external genital area?
□ ♀**:** Is your menstrual blood thick and dark, or purplish in color?

Heart-

□ Do you wake up early in the morning and have trouble getting back to sleep?
□ Do you have heart palpitations, especially when anxious?
□ Do you have nightmares?
□ Do you seem low in spirit or lacking vitality?
□ Are you prone to agitation or extreme restlessness?
□ Do you fidget?
□ Do you sweat excessively, especially on your chest?

Excess Heat

□ Are your mouth and throat usually dry?
□ Are you often thirsty for cold drinks?
□ Do you often feel warmer than those around you?
□ Do you wake up sweating or have hot flashes?
□ ♀**:** Do you breakout with red acne, especially pre-menstrually?
□ ♀**:** Do you have a short menstrual cycle?
□ ♀**:** Do you have vaginal irritation?

Dampness

□ Do you feel tired and sluggish after a meal?
□ Do you have cystic or pustular acne?
□ Do you have urgent, bright, or foul-smelling stools?
□ Are you overweight?
□ Do you have a wet, slimy tongue?
□ Does your body feel like a barometer? Can you sense when it will rain?
□ ♀**:** Does your menstrual blood contain stringy tissue or mucus?
□ ♀**:** Are you prone to yeast infections and vaginal itching?
□ ♀**:** Do you have fibrocytic breasts?

♀**For Women**

Age of first period _____ Date of last period _____ Number of children (live births) _____
Number of days between periods (your cycle)_____Number of days of flow_____

♀ **Check All that Apply:**

Color of flow:
□ pale/light red □ red □ bright red □ dark red □ dark red/brown □ dark red/purple

Pain and Cramping: □ No □ Yes □ mild □ moderate □ severe

Other symptoms related to menses:

□ Discharge □ PMS □ Headache □ Nausea □ Constipation □ Diarrhea □ Swollen Breasts
□ Mood Swings □ Increased Appetite □ Decreased Appetite □ Insomnia

Have you ever been diagnosed with:

□ fibroids □ fibrocystic breasts □ endometriosis □ ovarian cysts □ PID □ polycystic ovary syndrome
□ STD

Fertility Information

# of IVF procedures_____# of IUI procedures_____

Has a physician diagnosed a difficulty with fertility due to:

□ Female Factor □ Male Factor □ Unexplained
□ Other _____

newbeginnings chiropractic

PATIENT NAME (PRINT) _____ DATE _____

Informed Consent for Treatment

I_____hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of such practices.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, slight bleeding, numbness or tingling near the needling sites that may last a few days, with possible drowsiness, dizziness or fainting. Very rare risks of acupuncture include spontaneous miscarriage, nerve damage and pneumothorax. I understand that the risk of infection is negligible when all needles are sterile. All needles are considered sterile when they are disposable; new beginnings will only use disposable one-time use sterile needles during your treatment.

I have had an opportunity to discuss with the doctor named below the nature and purpose of acupuncture and/or chiropractic medicine. I understand that results are not implied nor guaranteed.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment which the doctor feels at the time is in my best interest, based upon the facts then known, during the course of the procedure.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment. I understand that the doctor is not providing allopathic medical care, and that I should look to my primary care practitioner for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT'S NAME (print) _____

PATIENT'S SIGNATURE:_____ Date:_____

☐ I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment.

Doctors Signature:_____ Date:_____