QUINTESSENTIAL Wellness
CHIROPRACTIC • ACUPUNCTURE • MASSAGE

PATIENT INTAKE FORM

ACUPUNCTURE ASSESSMENT

Important: This is a CONFIDENTIAL questionnaire to help us 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.

Name:_____ Gender: M F Date:_____

Home Address:_____ City:_____

State:_____ Zip:_____ Email:_____

Birth date:_____ Age:_____ If under 18, person responsible for your account:_____

Home phone:_____ Work phone:_____ Cell phone: _____

Emergency Contact: Name:_____ Contact phone:_____

Marital Status: _____single _____married _____divorced _____widowed _____with a significant other

Are you a caregiver for dependents? Yes No If yes, how many children?_____ How many adults_____

Occupation:_____ Number of years in this type of work:_____

Retired: Number of years in retirement:_____ Occupation when in workforce *(please fill out the previous line)*

Primary care physician: Name:_____ Phone:_____

Insurance coverage circle one (Note: we do not accept insurance at this time, but can provide you with a statement for submissions to your company.)

None Workers' Comp Auto Injury Health Insurance Company

How did you hear about us? *Please circle one and write the name*

Current patient:_____ Friend:_____

Doctor:_____ Insurance:_____

Advertisement:_____ Other:_____

Have you had acupuncture before? Yes No If yes, with whom?_____ When_____

For what condition?_____

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

____hepatitis ____HIV ____high blood pressure ____seizures ____pacemaker ____blood-thinning meds

___pregnancy ____Surgically implanted joint/bone replacement or stabilizers

Are you currently under the care of any other health care provider (physician, chiropractor, therapist, massage therapist, etc.)? Yes No

If yes, please provide the name and title of the practitioner(s), the condition being treated and the length of time you have been receiving this treatment:

Practitioner Condition Length of treatment to present

_____

_____

_____

Please list all past medical conditions for which you were hospitalized and/or received surgery (include the dates).

_____

_____

_____

Current Health Concerns

Please list your health concerns in order of priority:

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____

What do you believe is causing your most important health concerns?_____

_____

What is your main reason for today's visit?_____

How long have you had this condition?_____

How does it impact your quality of life?_____

Have you seen a physician or other health practitioner about this?_____ When?_____

What was the diagnosis (if any)?_____

Describe any treatment you received and the results:_____

_____

What aggravates this condition?_____

What improves this condition?_____

Habits and Lifestyle

Do you smoke?_____ If yes, what?_____ How much per day?_____ Since when?_____

Do you drink alcohol?_____ If yes, what?_____ How much?_____ How often?_____

Do you exercise regularly?_____ If yes, please describe what you do:_____

Emotional stress scale *Please circle*

1 2 3 4 5 6 7 8 9 10

No Stress Moderate Extremely stressed

What do you do when you want to release stress and/or just relax?_____

How many hours do you usually sleep per night?_____ When do you go to bed?_____

Do you wake feeling refreshed?_____

What is your height?_____ What is your present weight?_____ What was your weight one year ago?_____

What is the most you have ever weighed?_____ When?_____

How often do you have a bowel movement?_____

Nutrition

Do you drink coffee?_____ If yes, how much per day?_____

Do you drink caffeinated tea?_____ If yes, how much per day?_____

Do you drink soda pop? regular diet none *(Please circle one)* If yes, for how long?_____

Do you have regular eating habits? Yes No

Do you eat while engaged in other occupations? Yes No

Do you eat more when under stress or feeling depressed? Yes No

Do you experience sudden drops in energy? Yes No If yes, when?_____

Please describe a typical day's diet for you:

Breakfast	Lunch	Dinner	Snacks(what hour?)

Family History

Please describe your family's health, including current age or age at death, and major illness history (diabetes, heart disease, osteoporosis, cancer, allergies, mental illness, etc.)

Member	**Living?/Age_____**	**Major Illness or Chronic Conditions**
Mother		
Father		
Sisters/Brothers		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

WOMEN ONLY *please circle response as appropriate*

Are you currently experiencing any gynecological symptoms or problems? Yes No
Are you currently sexually active? Yes No If yes, partner(s) is/are male female
If sexually active, do you perform safe sex practices? Yes No
Any problems related to sexual function? Yes No
Do you have any history of sexually transmitted diseases? Yes No
Do you have any history of cervical, ovarian, or breast cancer? Yes No
Do you perform regular breast self-exams? Yes No
How old were you at onset of first menses?_____
If you are of menstruating age: date of last period_____
periods generally last_____days and occur every_____days
bleeding is _____heavy _____moderate _____light
List any PMS symptoms:_____
_____

If you are menopausal or perimenopausal:
Are you taking hormone replacement therapy? Yes No
List and symptoms or concerns:_____
_____
Number of pregnancies and your age at each_____
Number of live births and your age at each:_____
Natural deliveries?_____ C-sections?_____
Are you currently trying to conceive? Yes No

MEN ONLY *please circle response as appropriate*

Are you currently sexually active? Yes No If yes, partner(s) is/are male female If sexually active, do you perform safe sex practices? Yes No
Do you have any history of sexually transmitted diseases? Yes No
Have you ever had a diagnosis of prostate enlargement or cancer? Yes No
Do you ever experience trouble with urination (frequency, hesitancy, pain, dribbling)? Yes No Do you ever experience trouble with sexual function/libido? Yes No

Symptoms *** **For each symptom you currently have, please rate its severity from 1 to 5 (5 being the worst). Leave blank if not applicable.*****

Liv/GB(wood)
_____irritability/anger
_____depression/stress
_____headaches/migraines
_____visual problems
_____red/dry/itchy eyes
_____gall stones
_____dizziness
_____blurred vision
_____feeling of lump in throat
_____clenching of teeth at night
_____muscle cramping/twitching
_____tension
_____joints/neck/shoulder pain
_____poor circulation
_____soft/brittle nails
_____emotional eater
_____ringing in ears
_____eczema
_____Shingles
_____herpes simplex
_____indecisive
_____fullness below ribs
_____shoulder/neck tension
_____insomnia 11pm-3am

Lu/LI (Metal)
_____dry cough
_____cough with sputum
_____nasal discharge
_____post-nasal drip
_____sinus trouble
_____itchy/red/painful
_____dry mouth/throat/nose
_____skin rashes/hives
_____snoring
_____grief/sadness
_____shortness of breath
_____asthma/allergies
_____low resistance to colds or flu
_____sneezing
_____mild fever comes and goes
_____smoke cigarettes
_____bronchitis

Ht/SI (Fire)
_____heart palpitations
_____chest pain
_____insomnia/sleep problems
_____easily startled
_____restlessness/agitation
_____vivid dreams
_____lack of joy in life
_____dry scalp
_____skin rash
_____cysts/tumor
_____ear infection
_____sore throat
_____lymph swelling
_____hot palms/soles
_____aversion to heat
_____bitter taste in mouth
_____gum problems
_____nose bleed
_____facial redness
_____itchy/burning skin
_____thirst
_____dark blue
_____night sweats
_____excess joy

Kid/UB (Water)
_____urinary problems
_____bladder problems
_____lack of bladder control
_____weakness/pain in lower back
_____decreased bone density
_____feel cold easily
_____low sex drive
_____excess sexual drive
_____poor memory
_____loss of hair
_____hearing problems
_____cavities/tooth loss
_____craving/avoiding salty foods
_____fear
_____hot flash/night sweating
_____dark under eyes
_____weak leg/knees
_____rapid weight change
_____emotional instability
_____thyroid problems

Sp/ST (Earth)
_____heaviness anywhere in body
_____fatigue/worse after eating
_____hard to get up in morning
_____edema (swelling)
_____muscles feel tired often
_____easily bruising and bleeding
_____bad breath
_____decreased/increased appetite
_____crave sweets
_____hypoglycemia
_____difficulty digesting oily foods
_____nausea/vomiting
_____gas/belching
_____insulin sensitivity
_____hemorrhoids
_____constipation
_____diarrhea
_____abdominal pain
_____indigestion/heartburn
_____over-thinking
_____tendency to gain weight
_____brain foggy
_____food allergy
_____excess worry

OTHER
_____fatigue
_____arthritis
_____sciatica
_____nerve pain
_____carpal tunnel
_____numbness
_____cold hands/feet
_____bursitis/tendonitis

Medications/Supplements

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them.

Medications----------	Reasons----------	Date Began-----	Dose-----	Helps Yes or No

Supplements	Reason	Date Began	Dose	Helps Yes or No

Please describe any other health concerns not previously covered in this form.

_____

_____

_____

_____

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Signature_____ Date_____

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Acupuncture Informed Consent to Treat

FORM MUST BE SIGNED BY ALL PARTICIPANTS. IF PARTICIPANT IS UNDER 18 YEARS OF AGE, FORM MUST BE SIGNED BY MINOR AND HIS/HER PARENT/GUARDIAN.

I hereby request and consent to the performance of acupuncture treatments and other procedure within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Amanda Keates and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with Quintessential Wellness, LLC.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustation, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including: bruising, numbness or tingling near the needle sites that may last a few days and dizziness or fainting. Burns and /or scarring are a potential risk of moxibustation and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include: spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pnuemothorax). Infection is another possible risk, although sterile disposable needles are used with all patients to maintain the safest and most sterile treatment environment possible.

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) that have been recommended are traditionally considered safe in the practice of Chinese medicine, 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, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Participant:_____

Signature of Participant:_____ Date:_____

MINOR INFORMATION:

Name of Parent/Legal Guardian:_____ Age (If A Minor)_____

Signature of Parent/Legal Guardian:_____ Date:_____