Jodi Rose M.S Lac

bodyu n b o u n d Acupuncture   Acupuncture Intake Form

Chinese Medical Diagnosis requires thorough, honest feedback from the client. The accuracy of the information provided will directly benefit the effectiveness of your treatments. Thank you for taking the time to complete this form to the best of your ability.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name______________________

Phone number_____________

Email____________________

Date of Birth____________________
Address______________________City______________State________Zip______
Gender: M F MTF FTM other________

Preferred pronoun: he/him/his she/her/hers other_________

In case of emergency contact_________________
Phone________________________
Relationship_______________________________

Please describe the reason for your visit today___________________

Is it getting better, worse, or staying the same?
____

Are you, or have you been, treated for this problem with any other health professionals? Is it effective?_____________________________

Have you had acupuncture before?_______________

Why?___________________

When?___________________

Has it been effective?
____

Are you taking any medication or herbal supplements? If so, which ones? (Include dosage if know)____

MEDICAL HISTORY

Please circle any current health issue. For those diseases which are part of your health history, please note the year of the occurrence.

Allergies

Anemia

Appendicitis Arteriosclerosis

Asthma

Autism/ Asperger's/ ASD ADD/ OCD Bleeding Disorder

Blood Pressure (Low or High) Cancer

Chicken Pox

Diabetes

Digestive Disorders

Emotional Difficulties

Emphysema Epilepsy

Fatigue

Gout

Heart Disease

Hepatitis (A, B,C)

Hypoglycemia

Injuries Insomnia

Intestinal Parasites

Multiple Sclerosis

Mumps Pacemaker
Polio
Scarlet Fever Stroke

Thyroid Disorder

Trauma

Falls, Accidents

Tuberculosis

Ulcers

Weight Loss or Gain Other

Please list any surgeries or medical procedures with dates:____
____
____

Do any of your family members suffer from: (Please list relationship to you)

Alcoholism Allergies (list) ______________ ______________

Arteriosclerosis Asthma_________________ __________________
Cancer ______________________ ____________________

Diabetes ______________________ _____________________

Heart Disease__________________ ___________________
High Blood Pressure ___________________ _____________

Seizures____________________ ________________
Stroke__________________ __________________

Which of the following lists are included in your lifestyle? Indicate frequency/ quantity:

Alcohol Nicotine _____________Exercise______________
Coffee_____________ Recreational Drug Use__________.
Excessive Sugar ___________

Do you usually eat three meals a day? _________

Do you follow any particular diet?_____

Do you have any known food allergies or sensitivities?

On the scale of 1-10, how would you rate the level of stress in your life currently?

What is the level of stress in your life in general (1-10)?

How does stress affect you? (ie, more headaches, stomach pain, etc.)

____

REVIEW OF SYSTEMS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue!

Currently experiencing the symptom

*circle it ◯

Experienced it in your past

*check it ✓

Head and Face

Headaches Dizziness MemoryLoss Other

Eyes

Blurry Vision

Eyelid Twitching Floaters

Pain

Nose

Frequent Colds Sinus Trouble Bleeding

Mouth

Dental Problems Gum Problems Teeth Grinding/TMJ Unusual Tastes Other

Throat

Sore Throat Hoarseness Difficulty Swallowing Dryness

Other

Respiration

Difficulty Inhaling Difficulty Exhaling Pain Cough

Congestion Shortness of Breath Other

Heart and Chest

High Blood Pressure Low Blood Pressure

Chest Pain Chest Tightness Difficulty Lying Down

Other

Circulation

Easy Bruising Easy Bleeding

Cold Limbs-Hands or Feet Reynaud's Syndrome

Gastrointestinal

Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain Nausea

Diarrhea/Loose Stools Constipation
Rectal Bleeding Colon Problems

Urination

Frequent Difficult Painful Nocturnal Bleeding Other

Skin Acne. Dryness Moles that Change Lumps
Excessive Sweating Night Sweats Rarely Sweat
Other

Neurological

Nervousness/Anxiety Tremors
Numbness or Tingling Lack of Coordination Nerve Pain

Sleep

Insomnia -Drowsiness- Excessive Dreaming -Waking Easily Other

Pain - Describe your pain…

____
____
____
____

Are there any other health concerns you'd like to address?

____
____
____

Do you currently or have you ever had a menstrual cycle? Y or N

If no, please continue

Are you, or could you be pregnant?_____ If so, how far along?____________
Number of pregnancies______ Births________

Abortions_____Miscarriages__________ What form, if any, of birth control do you use?_________________________________ Age of first menses_________

Age of menopause, if applicable____________________ Do you bleed between periods?____

Have you ever had any gynecological surgeries or any abnormal findings on any tests?

____

Are your periods uncomfortable or painful, either emotionally or physically?

____

Are your periods:
Short (< 28 days)______Long (30+ days)______

Average_______(28-30days) Varied______________

Painful? If so, Before________ During________ After_________
Quality and location of pain________________________________
Do you bleed heavily_________? Lightly________? Very little?__________
Do you have clots ?_______ Early in the cycle_______ or throughout?__________
Relative to the blood that comes from a wound, is your menstrual blood:
Similar color________Pale_______ Purple_______ Bright Red_______
Dark Red_________ Brown__________ Black___________
How many days do you bleed?___________
Do you have any of the following Pre-Menstrual Symptoms?

Please keep in mind that, in Chinese medical theory, emotions are paired with organs and channels; Your accuracy and honesty can be essential to diagnosis and an individualized treatment plan~

Irritability____ Depression______ Crying______ Rage______ Nausea_________
Cravings, and if so for what?______________Breast Tenderness______________
Irrational thought or behavior__________________

Do you have any other gynecological concerns or complaints?

____
____
____
____
____

____

____

Do you experience any of the following:
Reduced Libido________ Excessive Libido_________ Impotence_____________
Premature Ejaculation__________
Genital/ Testicular/ Labial pain________________________________

Vaginal/ Penile Discharge ________If yes, what color and quantity?
Urinary Frequency or Incontinence______________________________
Any other concerns?

____

I have provided correct and complete information to the best of my knowledge.

Patient's or Guardian's signature Date

____

Acupuncture Consent to Treatment

I hereby request and consent from, Jodi Rose Ms. LAc ,the performance of Acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for which I am legally responsible).

I understand that methods or treatments may include, but are not limited to, Acupuncture, moxabustion, cupping, bloodletting, electrical stimulation, Medical Qi Gong, Gua Sha, Chinese or Western Herbal Medicine, nutritional counseling and/or supplementation, and magnets.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain and to treat certain diseases and dysfunction of the body. I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. I do not expect the Acupuncturist to be able to anticipate all risks and complications. I wish to rely on the Acupuncturist to exercise judgment

during the course of the procedure which the Acupuncturist feels at the time, based on the facts then known, is in my best interests. __________**initials**

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. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the Acupuncturist immediately. __________**initials**

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss any emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.

I agree to pay all charges incurred for services rendered and I agree to pay the full charge for any missed or forgotten appointments without 24- hour notice of cancellation unless specific arrangements have been made with the Acupuncturist. __________initials

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:_____________________DOB__________

Patient (or patient representative)
signature:_______________________________Date______

Name of Licensed Acupuncturist: Jodi Rose M.S L.Ac,

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of
Patient:____

Patient's
Representative:____

Relationship of Authority of
Patient:____