# One Life Wellness Studio
# Acupuncture
# Client Intake Form

## PATIENT INFORMATION

Name_____

Address_____

City State Zip_____

Age_____ Date of Birth_____

Height _____ Weight _____

Occupation _____

Employer _____

Primary physician _____

## CONTACT INFORMATION

Date_____

Cell/Primary phone _____

Email _____

Another person we may contact in case of emergency:

Name _____

Relationship_____

Primary phone _____

How did you hear about us? _____

## HEALTH HISTORY

What are your primary health concerns?

1 -_____

2 - _____

3 - _____

List medications or supplements you are taking:

_____

_____

_____

List any serious illness, surgery, physical injury, emotional trauma, or medical diagnosis (include year):

_____

_____

_____

_____

_____

Marital Status _____ # children _____

Energy level (1-10) _____

Stress level (1-10) _____

Sources of stress _____

# hrs sleep per night _____

# hrs exercise per week _____

Methods of exercise _____

Check illnesses that have occurred in immediate relatives:

☐Heart disease ☐Alcoholism ☐Cancer _____
☐Depression ☐Diabetes ☐Stroke ☐Mental Illness
☐Other _____

Check symptoms you have or have had in the past with some significance:

**DIET**

- □ Food sensitivities_____
- □ Cravings _____
- □ Vegetarian/vegan
- □ Excess sugar intake
- □ Excess caffeine/alcohol
- □ Not enough water
- □ Not enough fruits and vegetables
- □ Increased/decreased appetite (circle)
- □ Excessive thirst

**GENERAL**

- □ Fatigue
- □ Poor or restless sleep
- □ Weight gain or loss (circle)
- □ Hepatitis/AIDS
- □ Anemia/bleeding disorder
- □ Diabetes
- □ Chills or fever (circle)
- □ Poor circulation/cold hands and feet
- □ Addiction/recovery
- □ Seasonal allergies/hay fever
- □ Specific allergies _____
- □ Cancer – type _____

**MUSCULO-SKELETAL**
- □ Muscular soreness _____ _____
- □ Arthritis _____
- □ Swollen/painful joints
- □ Osteoporosis
- □ Spinal/disc problems
- □ Migraines/headaches
- □ TMJ/jaw clenching or grinding
- □ Numbness/neuropathy

**RESPIRATORY/SENSORY**
- □ Asthma/wheezing
- □ Persistent cough
- □ Frequent colds
- □ Sinus problems
- □ Impaired vision-glasses or contacts
- □ Visual floaters
- □ Eye pain/dryness/redness
- □ Hearing loss
- □ Earache
- □ Ringing in ears
- □ Dizziness/Vertigo
- □ Gum recession/bleeding
- □ Sensitive teeth/toothache

**GASTROINTESTINAL**
- □ Indigestion/acid reflux
- □ Excessive gas
- □ Constipation
- □ Diarrhea
- □ Loose stool
- □ Abdominal bloating
- □ Hemorrhoids
- □ Ulcers
- □ Frequent nausea
- □ Stomach pain/cramps
- □ Hernia

**EMOTIONAL**
- □ Nervousness/anxiety
- □ Depression
- □ Difficulty focusing
- □ Poor Memory
- □ Excessive worry/over-thinking
- □ Irritability/frustration
- □ Timid/low self esteem
- □ Insecure/paranoid

**SKIN**
- □ Acne
- □ Bruise/bleed easily
- □ Varicose veins
- □ Dry/ oily/sensitive skin (circle)
- □ Itching/rash/hives
- □ General edema/ankle swelling
- □ Nail fungus
- □ Excessive Sweat- day or night
- □ Hair loss

**CARDIOVASCULAR**
- □ High or low blood pressure (circle)
- □ High cholesterol
- □ Heart attack/heart condition
- □ Heart palpitations/irregular heart beat

**GENITO/URINARY**
- □ Frequent urination
- □ Bladder infection/UTI
- □ Difficult urination/break in flow
- □ Incontinence/dribbling
- □ Kidney disease/stones
- □ Increased or decreased libido (circle)

**FOR MEN ONLY**
- □ Erectile difficulties
- □ Enlarged Prostate
- □ Genital pain/swelling

**FOR WOMEN ONLY**
- □ PMS/mood swings
- □ Bloating/water retention
- □ Irregular cycle
- □ Pregnant or possibly pregnant
- □ Menstrual clotting
- □ Excessive menstrual flow
- □ Extreme menstrual cramping
- □ Breast tenderness
- □ Cervical dysplasia
- □ Uterine/ovarian fibroids or cysts
- □ Menopausal symptoms/hot flashes
- □ Miscarriage
- □ Hysterectomy
- □ Difficult pregnancy or labor
- □ Vaginal discharge or dryness (circle)
- □ Frequent yeast infection

Ave length of cycle _____ Ave length of menses _____

**SIGNATURE**

The information on this form is correct to the best of my knowledge.

Signature_____ Date _____

# Patient Information and Consent Form

*Please read this information carefully, and ask if there is anything that you do not understand.*

**What is acupuncture?**
Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. It may be used for any health condition and by people of all ages (with the exception of infants and small children). The goal of acupuncture is to increase the immune response and encourage pain relief by stimulating the nervous system and increasing blood circulation. It is designed to balance the body and create a healthier being.

**Is acupuncture safe?**
Yes. Serious side effects are very rare – less than 1 per 10,000 treatments.

**Does acupuncture have side effects?**

You need to be aware that:

- Intense relaxation or drowsiness may occur after treatment in a small number of patients.
- Minor bleeding or bruising may occur after acupuncture and will go away on its own.
- Temporary pain may occur. This sensation will be momentary and may range from sharp, dull, tingling, heavy, or electric and will immediately subside.
- Symptoms may get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is generally a sign of healing.
- Fainting may occur in certain patients, particularly during the first treatment or on an empty stomach. Please be sure to eat a light snack before treatment.

**Is there anything your practitioner needs to know?**
Apart from the usual medical details, it is important that you let your practitioner know:

- if you are pregnant
- if you have a pacemaker or any other implants
- if you have a bleeding disorder
- if you are taking anti-coagulants or any other medication
- if you have damaged heart valves or have any other particular risk of infection
- if there are any particular risks that apply in your case

Your treatment may include acupuncture, therapeutic massage, moxibustion (heat therapy), herbal and dietary recommendations, or cupping and gua-sha (suction and scraping techniques used to exteriorize stagnation).
**Single-use, sterile, disposable needles are used in the clinic.**

**Cancellation and Payment Agreement**
Missed sessions will be charged. If an appointment is cancelled with less than 24 hours notice, (with the exception of illness or emergency situations) OR if you do not attend a scheduled appointment, the session fee will be charged to the credit card on file OR deducted from your prepaid package.

**Statement of Consent**
I confirm that I have read and understood the above information, and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

**Print Name** **Signature** **Date**

_____ _____ _____