Initial Intake Form

Acupuncture For Athletes, PLLC

Name _____ Date _____

Street Address _____ Date of Birth _____

City, State, Zip code_____ Referred by _____

Mobile Phone _____ Occupation _____

Work Phone _____ Physical Therapist _____

Emergency Contact Name and Number _____

We ask all clients to provide an email address, which we don't share. Once every few months we send out brief newsletters containing only information pertinent to our practice. Thank you for providing your email.

Email Address _____

Have you had acupuncture before? Y/N For what condition? _____

What would you like treated today? _____

How long have you had this condition? _____ Onset sudden / gradual

Symptoms are relieved by _____

Symptoms are made worse by _____

Medical diagnosis _____

Prescription Medications _____

In general, do you feel hot or cold? _____ Do you prefer hot or cold drinks? _____

Family Health History

Please note any medical conditions which run in your family: _____

Please note the major medical conditions of the following blood relatives:

Grandparents: _____

Mother: _____

Father: _____

Siblings: _____

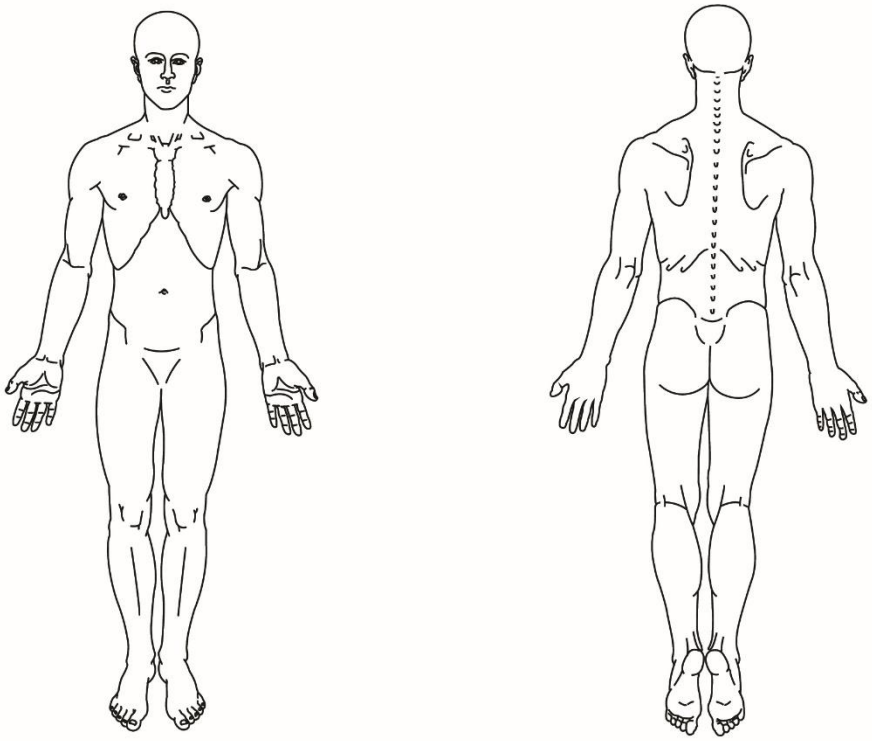
Personal Health History

O Alcoholism / Drug Abuse	O Hepatitis A/B/C (circle)	O Pacemaker	O Allergies
O Asthma	O Herpes	O Polio	O List Allergens:
O Birth Trauma (Yours)	O HIV/ AIDS	O Rheumatic Fever	_____
O Cancer / Tumors	O Latex allergy	O Scarlet Fever	_____
O Diabetes	O Lyme's Disease	O Seizures	_____
O Emphysema	O Lymph Nodes Removed	O Thyroid Problem	_____
O Heart Disease	O Multiple Sclerosis	O Tuberculosis	_____

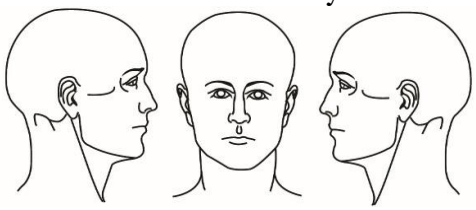
Please list all previous surgeries as well as all major illnesses or injuries:

Approximate Date:	Event:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please indicate areas of tension, pain or discomfort:



Please locate and describe any headaches that you experience:



Circle those items, which you have currently

Check those items; which you have had in the past

Cardiovascular
O Chest pain
O High blood pressure
O Low blood pressure
O Palpitations
O Cardiac procedure
O Rapid heart beat

Emotions / Sleep
O Anxiety
O Panic attacks
O Depression
O Frequent dreams / nightmares
O History of psychiatric treatment
O Insomnia
O Night sweats

Eyes / Ears
O Blurred vision
O See spots / floaters
O Ear infections
O Dizziness
O Ringing in ears
O Poor hearing

Female
O Pelvic area pain
O Breast lumps / disorders
O Clotting with menses
O Frequent vaginal infections
O Frequent vaginal discharge
O Irregular periods
O Light flow / Heavy flow
O Menopausal symptoms
O Ovarian cysts
O Uterine fibroids
O Painful periods
O Premenstrual symptoms
Avg. # of days in full cycle:
Avg. # of days of menstruation:

Gastrointestinal
O Abdominal pain
O Abdominal bloating
O Acid reflux
O Belching / Gas
O Constipation
O Diarrhea
O Food cravings
O Gallbladder disorder
O Hemorrhoids
O Hernia
O Nausea / Vomiting
O Painful bowel movements
O Poor appetite
O Excess hunger

Headaches
O At night
O During day
O Sharp
O Dull

Male
O Testicular issues
O Impotence
O Pelvic area pain
O Prostate issue

Musculoskeletal
O Abnormal spinal curve
O Neck pain
O Middle back pain
O Lower back pain
O Joint issues: _____
_____
O Numbness / Tingling
O Radiating pain
O Spinal disc condition
O Spinal surgery
O Tendinitis / Bursitis

Nose / Throat / Mouth
O Bleeding gums
O Cold sores
O Frequent sore throat
O History of dental problems
O Sinus infections
O Frequent thirst
O No thirst
O Toothaches
O TMJ problem
O Oral herpes
O Oral surgery
O Do you smoke? Y/N
When did you start?

Skin
O Acne
O Bruise easily
O Dry skin
O Eczema
O Itchy skin
O Unusual sweating

Respiratory
O Asthma
O Chest constriction
O Chronic runny nose
O Chronic cough
O Cough with blood
O Cough with phlegm
O Dry cough
O Frequent colds

Urinary
O Burning urination
O Frequent urination
O Painful urination
O Kidney stones
O Weak stream
O Urinary tract infections

1. Advisory to Consult Physician

While Chinese Medicine has a great deal to offer as a health care system, it cannot replace the resources available through physicians. New York State education law article 160 requires that acupuncturists "advise each patient as to the importance of consulting with a licensed physician regarding the patient's condition." I, (**print name**) _____ , have been advised by the staff at Acupuncture For Athletes to consult a physician regarding the conditions for which I seek treatment.

2. Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for Acupuncture For Athletes, detailing how my information may be used and disclosed as permitted under federal and state law. I understand that I can request a copy of this notice for my records.

3. Informed Consent

Acupuncture is a safe method of treatment, but it may have side effects. Bruising is the most common side effect. Other much less likely side effects include numbness or tingling near the needling sites that may last a few days as well as dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk. This office uses sterile, single-use needles and maintains a clean and safe environment. Of note, burns and scarring are potential risks of using moxibustion.

I consent to acupuncture treatments, along with its adjunct therapies, by the practitioners at Acupuncture For Athletes. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect my providers to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on them to exercise judgment during the course of treatment and decide what they think is in my best interest, based upon the facts that are known at the time. I understand the staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent. **I will notify the staff if I am or if I become pregnant.**

By voluntarily signing below, I show that I've read this consent to treatment and read about the risks of acupuncture. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Please Note: Clients at Acupuncture For Athletes may see more than one staff acupuncturist over the course of treatment. For the purposes of providing the best care possible, staff members may communicate with each other regarding conditions and treatment plans. By initialing here, I consent to this communication.

Please Initial Here: _____

4. Signature, indicating agreement with items one, two and three above

_____ _____

Signature of client Date