Jodie Manross Acupuncture Intake form

Please Note: The information provided on this form is confidential. Today's Date ___ /___/___

Name: _____ Age: _____ Sex: Male Female

Address_____ Occupation _____

City_____ State_____ Zip_____ Date of birth ___/___/___

Telephone: Cell/ Best # for reminder texts _____ E-mail _____

How did you hear about me? _____

Physician's care? _____Name & phone of physician: _____

What would you like treated by Acupuncture? _____

How long have you had this condition? _____ Was onset: sudden or gradual

Symptoms are worse by_____ Symptoms better by _____

What medical diagnosis have you received? _____

What other treatments have you received for this and/or other conditions? _____

How has this condition changed your life? _____

_____

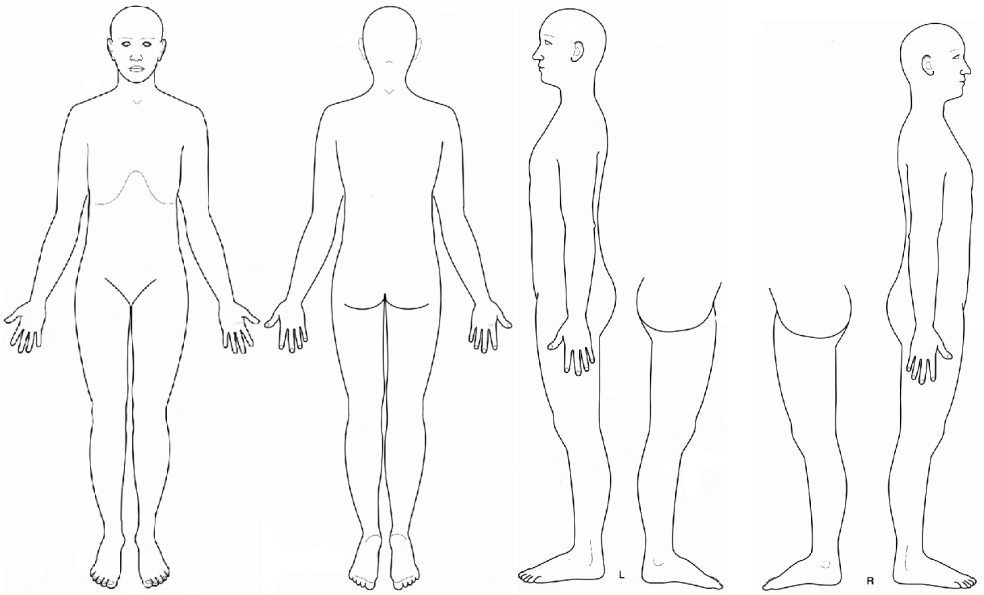
Are you taking any medication? Please note all medications, herbs, vitamins, and minerals you take:

_____

_____

Are you <u>currently</u> pregnant or <u>presently</u> trying to get pregnant? Yes No

On the following drawing, shade the areas you would like to be addressed.



Medical History

Birth: Anything significant about your birth (premature, breech, jaundice, etc.)? _____

Childhood illnesses: Any surgery or accidents? Please list in chronological order and indicate length of illness or injury.

____age: _____

_____

____age: _____

Adolescence illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

____age: _____

_____

____age: _____

Adulthood: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

____age: _____

_____

____age: _____

_____

____age: _____

Family history: Please note all major illnesses in your close family such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, etc.

_____

_____

Circle current conditions. Underline **former conditions**. **Have you had any of these?**

Allergies	Cancer	Lyme Disease	Seizures
Alcoholism	Diabetes	Multiple Sclerosis	Tuberculosis
AIDS/HIV	Emphysema	Pacemaker	Polio
Asthma	Heat Disease	Lymph nodes removed	Rheumatic Fever
Hepatitis A/B/C	Migraines	Headaches	Birth Trauma (your own birth)
Herpes	Hypothyroid	Hyperthyroid	
Osteoarthritis	Rheumatoid Arthritis		Scarlet Fever

Diet and Food:

How is your appetite? Good Poor No Appetite Hungry all the time

Any food cravings (sweet, salty, etc.?) _____

List any food intolerances or allergies: _____

Exercise and Energy:

Do you fatigue easily? _____

Does movement make you feel less tired or more tired? _____

How often do you exercise? What kind of exercise do you enjoy? _____

Do you have unusual sweating? _____ Do you get dizzy with or after exercise? _____

Emotions and Sleep:

Do you have (circle all that apply): Panic attacks Depression Anxiety Bad Temper

Nervousness Fear attacks Poor memory Difficult concentration Moody in the morning

If you hold your stress in the body, where? (for example, neck and shoulders or stomach) _____

How do you relax? _____

How do you feel about your work? _____

How long do you normally sleep? _____ hours per night

I have difficulty with (circle all that apply): Falling asleep Staying asleep Disturbed Sleep (nightmares)

Skin and Hair:

I have (circle all that apply): Dry skin Skin rashes Itching Acne Eczema Hives

Hair loss Premature graying Psoriasis Other_____

Respiratory, Eyes, Ears, Nose, Throat & Head:

Do you smoke? Yes No if yes, _____ per day, for _____years

I have (circle all that apply): Frequent colds Chronic runny nose Chronic cough Asthma Dizziness

Pain inhaling Shortness of breath on exertion/at rest Dry mouth Nose bleeds Bleeding gums

Pain/red eyes Poor vision See spots (floaters) Cold sores Frequent sore throat Sinusitis Vertigo

Ear pain Ringing in ears (high pitch / low pitch) Clogged/popping ears Motion sick Headaches/migraines

Cardiovascular:

Have you been diagnosed with heart trouble? Yes No

I have (circle all that apply): High Blood Pressure Chest Pain Heart Palpitations Irregular Heartbeat Phlebitis

Varicose veins Cold hands and feet Poor circulation Diabetic Neuropathy

Gastrointestinal:

I have (circle all that apply): Belching Nausea Vomiting Vomiting of blood Ulcers

Acid regurgitation Heartburn Hernia Indigestion Severe stomach pains

Irregular Constipation Diarrhea Gas Burning Hemorrhoids

Use laxatives Undigested food in stool Loose stool Hard stool Blood in stool

Muscles, Joints and Bones:

Do you have pain or tightness? Where? _____

The pain is (circle all that apply): Sharp Aching Numb Deep Pain Dull Pain

Burning Superficial pain Tingling Pain worse or better with heat Pain worse or better with cold

Is Pain worse in am or pm Is Pain worse or better with movement

I have (circle all that apply): Swollen joints Arthritis/joint pain Tendonitis Rheumatism

Bone pain Muscle cramping Muscle pain Repetitive strain TMJ

Urinary & Genital:

I have or have had (circle all that apply): Trouble starting stream frequent urination

Incontinence Trouble holding urine Pain Burning Dribbling when sneezing

Urinary tract infections Blood in urine Kidney stones Pain during sexual relations

Women:

I have (circle all that apply): Irregular menstruation Heavy flow Light flow

No flow Clots Vaginal itching/burning Spotting between periods

Discomfort/pain before period Discomfort/pain during period Lumps in the breast Breast tenderness

PMS symptoms: _____

What makes these symptoms better? _____

Number of pregnancies? _____

Pregnancy complications? Please describe: _____

Are you in Menopause or Perimenopause?

Menopausal Symptoms: _____

Do you experience any hot flashes or night sweats? _____

Informed Consent

While Acupuncture and Oriental Medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s).

I consent to acupuncture treatments and related procedures, associated with Acupuncture and Oriental Medicine, by Jodie Manross, L.Ac. I have discussed the nature and purpose of my treatment with her, and I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha and electrical stimulation.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the acupuncture needle sight, which may last a few days.

An extremely unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ puncture. Infection is another rare, possible risk, however since this office uses only **sterilized**, disposable needles while maintaining a **clean and safe environment**, this is highly unlikely.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand that the practitioner and administrative 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 acupuncturist, who is caring for me, if I become pregnant.
By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I 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 form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment(s).

_____

Signature of patient or patient representative/parent/guardian

_____

Date

_____

Signature of Practitioner (Jodie Manross)

_____

Date