Important: The information on this form will help your acupuncturist to give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

Personal and Contact Information

LastName:_____ First Name:_____ Middle Initial: _____

Primary Telephone Number:_____ Alt. Phone #_____

E-Mail:_____ Date of Birth____ / _____ / _____ Age: _____

Address:_____ City: _____ State: _____ Zip:_____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

Spouse's Name :_____ Spouse's Age:_____ Occupation:_____

In case of emergency, whom should we notify?_____ Relationship:_____

Contact Number: _____

How did you hear about our office? _____

Primary Care Physician: _____

Please list all medications (prescribed and over-the-counter), vitamins and supplements you are currently taking:

_____

_____

_____

General Health Information

Major Health Complaint(s). Please list any health concerns or complaints that you have in order of their significance.

Major Health Complaints / Symptoms	Additional Health Complaints / Symptoms
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Please explain how these conditions affect or impair your daily activities

_____

_____

Describe your symptoms when they are at their worst: _____

_____

Are there any other complaints or conditions that you would like us to know about?_____

_____

Louisville Acupuncture Clinic

Medical Conditions and History (Check any conditions that you have had in the past, or are currently experiencing):

- ☐ Diabetes*
- ☐ Heart Disease*
- ☐ Asthma
- ☐ Hepatitis
- ☐ Syphilis
- ☐ Meningitis
- ☐ Epilepsy
- ☐ Paralysis
- ☐ Lung disease
- ☐ Gonorrhea
- ☐ Acute respiratory distress*
- ☐ Suspected fracture or dislocation*
- ☐ Allergies
- ☐ Stroke
- ☐ Pneumonia
- ☐ Gonorrhea
- ☐ Measles
- ☐ HIV
- ☐ High Fever
- ☐ Cancer*
- ☐ Heart disease
- ☐ Chlamydia
- ☐ Undiagnosed Neurological changes*
- ☐ Glaucoma
- ☐ Vein condition
- ☐ Tuberculosis
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Polio
- ☐ Hepatitis
- ☐ Migraines
- ☐ Liver disease
- ☐ High Cholesterol
- ☐ Unexpected weightloss*
- ☐ Acute severe abdomin pain*
- ☐ Rheumatic fever
- ☐ Thyroid disorder
- ☐ Emphysema
- ☐ Bleeding or hemorrhage*
- ☐ Nervous disorder
- ☐ Auto Immune Disease
- ☐ Hypertension*
- ☐ Mental Illness
- ☐ Kidney disease
- ☐ Irregular Pap Smear
- ☐ Suspected Systematic infection*
- ☐ Other _____

* Per the State of Kentucky, items indicated by an asterisk require the care of a physician prior to treatment with acupuncture.

Hospitalizations, Surgeries	X-Rays, CAT Scans, MRIs, Special Studies
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Stress Assessment

How would you rate your current stress level? (1 being the least, 10 being the highest) 1 2 3 4 5 6 7 8 9 10

In what areas of your life do you feel the most stressed? Circle all that apply: Job/Career - Health Partner/Spouse relationship - Parents/Family - Financial - Friends - Other(s): _____

What are your main source(s) of support? Spouse/Partner - Family - Friends - Workplace - Church Support group - Therapist - God/Prayer - Myself (I primarily rely on myself alone to deal with difficult issues)

Are you using any of the following methods of relaxation and/or healing? Massage therapy - Physical exercise Meditation - Prayer - Yoga - Guided imagery - Energy Work - Others: _____

Have you ever experienced any major traumas? ☐ Yes ☐ No

Explain: _____

_____

_____

How many hours per night do you sleep? _____ **Do you wake rested?** ☐ Yes ☐ No

Hours / week at work? _____ **Do you enjoy work?** ☐ Yes ☐ No

Why / why not? _____

Please check any of the following symptoms that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organ's function)

Body Temperature (Kidney Organ System)

☐ Cold hands	☐ Hot body temperature	☐ Profuse perspiration	☐ Perspire easily
☐ Cold feet	☐ Cold body temperature	☐ Lack of perspiration	☐ Night time urination
☐ Sweaty palms	☐ Afternoon flushing	☐ Night sweating	
☐ Sweaty feet	☐ Hot flashes	☐ Strong thirst	

Energy and Stamina (Lung and Kidney System)

☐ Easily fatigued	☐ Lethargy	☐ Easily prone to illness	☐ Wheezing
☐ Shortness of breath	☐ Sweating without exertion	☐ Frequent colds / flus / sinuses	☐ Chronic allergies

Blood Function (Liver, Heart and Spleen System)

☐ Dizziness	☐ Tingling in extremities	☐ Itchy or dry	☐ Blurry vision
☐ Poor night vision	☐ Poor memory	☐ Scanty menses	☐ Tinnitus
☐ Floaters	☐ Difficulty concentrating	☐ Fainting	☐ Weak or brittle nails

Heart Function

☐ Heart palpitations	☐ Manic moods	☐ Forgetfulness	☐ Tongue ulcers
☐ Anxiety	☐ Restless dreams	☐ Hallucinations	☐ Speech impediment
☐ Mental restlessness	☐ Insomnia	☐ Depression	☐ Severe shyness
☐ Chest Pain	☐ Arrhythmia	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Hemophilia	☐ Rapid Heart Beating	☐ Heart Murmur	☐ Mitral valve prolapse

Lung Function

☐ Persistent cough	☐ Chronic allergies	☐ Dry or flaky skin	☐ Post nasal drip
☐ Nosebleeds	☐ Nasal dryness	☐ Sneezing	☐ Difficulty breathing
☐ Sinus congestion	☐ Sore throats	☐ Asthma	☐ Cigarette smoking

Allergies to ☐ Mold ☐ Cedar ☐ Pet fur ☐ Dust ☐ Pollen ☐ Oak ☐ Hay Fever ☐ Environmentally Sensitive

If you are a smoker, # of cigarettes per day _____ How long have you been smoking? _____

If you are a smoker, do you want to quit? ☐ Yes ☐ No [Level of determination to quit - 1 2 3 4 5 6 7 8 9 10]

Spleen Function

☐ Low or weak appetite	☐ Abdominal bloating	☐ Gurgling in intestines	☐ Hemorrhoids
☐ Abrupt weight gain	☐ Gas	☐ Fatigue following a meal	☐ Hypoglycemia
☐ Abrupt weight loss	☐ Strong food cravings	☐ Bruise easily	☐ Indigestion

Stomach Function

☐ Stomach ache	☐ Bad breath	☐ Stomach ulcer	☐ Nausea
☐ Acid reflux	☐ Bleeding gums	☐ Belching	☐ Vomiting
☐ Ravenous appetite	☐ Heartburn	☐ Hiccups	☐ Mouth ulcers

Typical Meals

Breakfast:_____ Lunch:_____

Dinner:_____ Snacks:_____

How many glasses of water do you drink per day? _____

Food allergies: ☐ Corn ☐ Wheat ☐ Dairy ☐ Eggs ☐ Soy ☐ Other _____

Bowel Function and Elimination (Intestinal Function)

- ☐ Loose stools
- ☐ Diarrhea
- ☐ Incomplete stools
- ☐ Constipation
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Difficulty moving bowels
- ☐ Small, hard, dry stools
- ☐ Less than 1 BM/ Day
- ☐ I.B.S. or Colitis
- ☐ Crohn's Disease
- ☐ Eating Disorder

Accumulated Dampness

- ☐ Mental fogginess
- ☐ Mental sluggishness
- ☐ Poor mental focus
- ☐ Heaviness of the head, the limbs, or of the whole body
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Joint stiffness / ache
- ☐ Edema in the legs
- ☐ Edema in the abdomen
- ☐ Chest congestion
- ☐ Symptoms worsen in rainy weather

Liver and Gall Bladder Function

- ☐ Chest pain
- ☐ Chest tightness
- ☐ All over body tension
- ☐ Muscle spasms
- ☐ Muscle cramps
- ☐ Seizures
- ☐ Alternating diarrhea and constipation
- ☐ Irritability
- ☐ Easy to anger
- ☐ Easily frustrated
- ☐ Convulsions
- ☐ Numbness / tingling
- ☐ Lump in throat
- ☐ Depression
- ☐ Pain in the ribcage
- ☐ Heaviness in ribcage
- ☐ Chronic neck tension
- ☐ Shoulder tension
- ☐ Ringing in ears
- ☐ Overwhelmed easily by stressful circumstances
- ☐ Skin rashes
- ☐ Acne
- ☐ Headaches
- ☐ Migraines
- ☐ Gall stones
- ☐ Teeth grinding / TMJ

Eyes (Liver Function)

- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Watery eyes
- ☐ Grittiness
- ☐ Poor night vision
- ☐ Red and irritated
- ☐ Bloodshot
- ☐ Seeing spots
- ☐ Near sighted
- ☐ Far sighted
- ☐ Astigmatism
- ☐ Glaucoma

Kidney and Urinary Bladder Function

- ☐ Frequent cavities
- ☐ Broken / loose teeth
- ☐ Weak bones
- ☐ Ringing in the ears
- ☐ Weak knees
- ☐ Knee soreness
- ☐ Low back pain
- ☐ Prostate problems
- ☐ Cold lower back
- ☐ Cold hips / buttocks
- ☐ Cold knees
- ☐ Incontinence
- ☐ Hair loss
- ☐ Early graying of hair
- ☐ Hearing loss
- ☐ Quick to fear / fright

Urinary Function

- ☐ Normal color
- ☐ Dark Yellow
- ☐ Clear color
- ☐ Difficulty initiating the stream of urination
- ☐ Reddish color
- ☐ Cloudy
- ☐ Strong odor
- ☐ Small amount
- ☐ Large amount
- ☐ Very frequent
- ☐ Dribbling
- ☐ Night-time urination
- ☐ UTI / Pain or burning
- ☐ Hesitancy
- ☐ Weak stream

Libido Function

- ☐ Normal
- ☐ Pain with intercourse
- ☐ High sex drive
- ☐ Fatigue following sexual activity
- ☐ Diminished sex drive
- ☐ Vaginal dryness
- ☐ Infertility

Louisville Acupuncture / Common Ground Wellness Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods may include, but are not limited to, acupuncture, moxibustion, 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 be 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, soreness, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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, stomachache, 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 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 that then known is in my best interest. I understand that results are not guaranteed.

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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek.
- I acknowledge my rights under HIPAA and that my personal information will only be shared with my consent. 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.
- I acknowledge I am responsible to pay for services rendered, whether or not there are insurance benefits that cover my treatments.
- I acknowledge I may be charged the full fee for treatment if I cancel my appointment in less than 24 hours or fail to show up at my appointment time.

Patient name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____