United Integrated
Healthcare Center

# Men's Acupuncture Intake Form

Name: _____ Date: _____

Address: _____ Zip: _____

Home: _____ Cell: _____

email: _____

Whom may we thank for referring you to our office? _____

Sex: ☐ M ☐ F Birthdate: _____/_____/_____

☐ Single ☐ Married/Partnership ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

## RESPONSIBILITY AGREEMENT WITH CONSENT TO TREATMENT AND STATEMENT OF FINANCIAL POLICY

**By signing below you acknowledge, understand and agree to the following:**

1. I am responsible for payment for all services rendered - co-payment, deduct and are due in full at the time of service. UIHC will help me to submit claim to my insurance company for covered services.
2. I understand that unless 24 hours advanced notice is given, I am financially responsible for cancelled or missed appointments.
3. I hereby consent to acupuncture and related holistic treatments and evaluations rendered to me (or my child if a minor) by UIHC's Licensed Acupuncturists. I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at anytime.
4. Acupuncture is a healing therapy involving the insertion of fine needles into specific points along meridians on the body. In addition to the use of needles, the scope of acupuncture includes the use of electrical, mechanical or magnetic devices to stimulate acupuncture points, moxibustion, acupressure, cupping and/or infra-red therapy.
5. Acupuncture side effects may include some pain following treatment in the insertion area, temporary aggravation of symptoms existing prior to treatment, minor bruising, slight bleeding, dizziness, infection or needle sickness (fainting).
6. **If you are pregnant, taking anti-coagulant drugs (Coumadin), have a bleeding disorder, diabetes, heart condition, circulatory problems, blood clots, blood borne disease such as HIV or Hepatitis, cancer/malignancies, bone disorders, metal implants or have a pacemaker you should make that information known to UIHC's Licensed Acupuncturists prior to treatment.**
7. Acupuncture treatment is a complement to and not a substitute for Western medical care. Certain conditions may best be addressed in partnership with other health care providers.
8. I understand that my acupuncture practitioner follows universally prescribed precautions to guard against the spread of infection by using only sterilized, prepackaged, disposable needles. These needles will only be used on me and are inserted according to clean procedures based on nationally prescribed standards.

I have read and understand/agree to the information on this consent form.

Name: _____ Date: _____

Signature: _____

## Acupuncture Patient Questionnaire

Have you had acupuncture before? □ Y □ N

Do you currently see a medical doctor? □ Y □ N

Name of Doctor: _____ Phone:_____

Address: _____

City: _____ St: _____ Zip: _____

Doctor's Diagnosis: _____

How are you responding to your present course of treatment? □ Better □ Worse □ Same

Date of last appt with regular Physician: _____

**Family Medical History:**

□ Cancer □ Diabetes □ Heart Disease □ Stroke □ Depression
□ Seizure □ Hepatitis □ Thyroid Disease □ Alcoholism □ High Blood Pressure
□ Other _____

**Please indicate if any of the following apply to you:**

| | | | |
|---|---|---|---|
| □ Cancer | □ Heart Condition | □ HIV/AIDS | □ Stroke/CVA |
| □ Diabetes | □ Hemophiliac | □ Lung Condition | □ Takes Anticoagulants |
| □ Epilepsy | □ Hepatitis | □ Pacemaker | □ Vegetarian/Vegan |

Surgeries: _____

Significant Trauma: _____

Birth History: _____

Allergies: _____

Exercise (type, duration, frequency): _____

Are you pregnant or is there any chance that you are pregnant? □ Y □ N

Medications: (list any medications, vitamins or food supplements taken in past two months)

| Name: | Dosage: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**WEIGHT:** _____ **HEIGHT:** _____

Have you experienced any height or weight gains/losses over the past year? □ Y □ N

Explain: _____

**LIFESTYLE:**

What are your primary sources of stress?

1.
2.
3.

How much do you think they impact you life? _____

How do you feel about the following areas of your life?

| | Great | Good | Fair | Poor | Bad | Comments: |
|---|---|---|---|---|---|---|
| Spouse/Significant Other | | | | | | |
| Family | | | | | | |
| Diet | | | | | | |
| Self | | | | | | |
| Work | | | | | | |
| Exercise | | | | | | |
| Spirituality | | | | | | |

Occupation? _____ Do you like your work? □ Y □ N

How many hours do you work per week? _____ Number of play/relaxation hours? _____

What do you do in order to manage stress and take care of yourself? : _____

_____

What do you believe is your greatest challenge? _____

What do you think you need to do in order for you vision of health to happen? _____

_____

What type of care do you desire?

- □ Temporary relief of symptoms/pain control
- □ Elimination of root cause of problem, if possible
- □ Maintenance care/balance to stay in good health
- □ Other _____

How would you classify your condition:

□ Minor □ Worsening □ Serious □ Severe/Life Altering

What other therapies have you tried for this condition: _____

**CURRENT MEDICAL STATUS:**

Date of last full physical? _____ If abnormal, explain:_____

Any personal history of skin cancer? □ Y □ N

If over age 50, have you had a colonoscopy? □ Y □ N Date of colonoscopy? _____

Any positive findings on colonoscopy? □ Y □ N If yes, explain:_____

Date of last eye exam? _____ If abnormal, explain: _____

Do you visit the dentist regularly? □ Y □ N How frequent? _____

Do you have dental problems, gum inflammation or gingivitis? □ Y □ N

Explain: _____

**DIET:**

Are you on a restrictive diet? □ Y □ N

Is your diet physician prescribed? □ Y □ N If yes, for what condition? _____

Do you consider your diet healthy? □ Y □ N

Please describe a typical day's diet…

| Breakfast | Lunch | Dinner | Snacks (what hou |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Estimated oz of water per day: _____

Caffeine Intake: □ None □ Coffee □ Tea □ Cola/Energy Drinks
# of cups/cans per day _____

Do you consume alcohol? □ Y □ N
If yes, what type? _____ How many drinks per week? _____

Do you use tobacco? □ Y □ N If yes, what kind? _____
How many per day? _____ Number of years used: _____

Do you use recreational drugs? □ Y □ N
Type of drug: _____ Frequency: _____

**INDICATE WITH NUMBERS AS FOLLOWS:** (Leave blank any symptoms which do not apply)

*1 – any condition occasionally experienced*
*2 – conditions which occur often*
*3 – symptoms which are a major concern*

**Water Element**
___ Asthmatic Cough
___ Cold Intolerance
___ Dark Under Eyes
___ Diabetes
___ Dizziness
___ Edema
___ Emotional Instability
___ Excess Fear
___ Frequent Urination
___ Hair Thinning/Loss
___ Hearing Loss
___ Kidney Stones
___ Loose Teeth/Loss
___ Low Back Pain
___ Neck Pain
___ Perspire Easily
___ Premature Aging
___ Rapid Weight Change
___ Reduced Sexual Energy
___ Sinus Congestion
___ Thyroid Problems
___ Weak Legs/Knees

**Wood Element**
___ Constipation
___ Convulsions
___ Dry Eyes
___ Eczema
___ Eye Infection
___ Fullness Below Ribs
___ Gallstones
___ Headaches
___ Hemorrhoids
___ Hepatitis
___ Herpes
___ Indecisive
___ Insomnia
___ Irritability
___ Migraines
___ Neck Tension
___ Nervousness
___ Poor Eyesight
___ Ringing In Ears
___ Shingles
___ Shoulder Tension
___ Spasms
___ Ulcer
___ Vomiting
___ Warts

**Fire Element**
___ Bitter Taste In Mouth
___ Cysts/Tumors
___ Dark Urine
___ Dry Scalp
___ Ear Infection
___ Excess Joy
___ Facial Redness
___ Gum Problems
___ Heart Palpitations
___ Heat Intolerance
___ Hot Palms/Soles
___ Itch/Burning Skin
___ Lymph Swelling
___ Night Sweats
___ Nose Bleeds
___ Skin Rash
___ Sore Throat
___ Thirst
___ Vivid Dreaming

**Other**
___ Arthritis
___ Bursitis/Tendonitis
___ Cold Hands/Feet
___ Fatigue
___ Nerve Pain
___ Sciatica

**Metal Element**
___ Allergies
___ Asthma
___ Bronchitis
___ Cough
___ Grief/Weeping
___ Nose Infection
___ Sinus Problems
___ Skin Problems
___ Weak Breath

**Earth Element**
___ Acid Reflux
___ Anemia
___ Big Appetite
___ Bloating
___ Diarrhea
___ Excess Worry
___ Flatulence
___ Food Allergy
___ Halitosis
___ Heartburn
___ Indigestion
___ Mouth Sores
___ Obsessive
___ Stomach Ache
___ Ulcer
___ Underweight
___ Weak Appetite

**Other Symptoms/Systems:**
Please indicate if you regularly experience any of the following:

**Head & Neck:**

- ☐ Dizziness ☐ Fainting ☐ Migraine
- ☐ Enlarged lymph glands ☐ Headache ☐ Stiff neck
- ☐ Other:_____

**Eyes & Ears:**

- ☐ Burning/itching eyes ☐ Dry eyes ☐ Ringing in ears
- ☐ Blurred vision ☐ Earache ☐ Spots/floaters
- ☐ Chronic ear infection ☐ Eye pain ☐ Vertigo
- ☐ Decreased hearing ☐ Poor night vision ☐ Visual changes
- ☐ Other:_____

**Respiratory/Nose:**

- ☐ Bronchitis ☐ Cough with phlegm ☐ Nasal congestion
- ☐ Chronic Cough ☐ Difficulty breathing ☐ Nosebleeds
- ☐ Chronic sinus infection ☐ Frequent Colds ☐ Shortness of breath
- ☐ Coughing up blood ☐ Hay fever/allergies ☐ Wheezing/Asthma
- ☐ Other:_____

**Genital/Urinary:**

- ☐ Bedwetting ☐ Frequent urination ☐ Nighttime urination
- ☐ Blood in urine ☐ Genital lesions/discharge ☐ Pain/itching of genitalia
- ☐ Decreased libido ☐ Kidney Stone ☐ Painful/burning urination
- ☐ Excessive/scant urination ☐ Increased libido ☐ Urgent urination
- ☐ Other:_____

**Cardiovascular:**

- ☐ Chest pain/tightness ☐ Irregular heart beat ☐ Swelling feet/ankles
- ☐ Heart palpitations ☐ Poor circulation ☐ Varicose veins
- ☐ Other:_____

**Mouth & Throat:**

- ☐ Bitter taste in mouth ☐ Dry mouth ☐ Recurrent sore throat
- ☐ Bleeding gums ☐ Lump in throat ☐ Tongue/Mouth sores/ulcers
- ☐ Difficulty swallowing

**Muscles & Joints:**

- ☐ Body aches/stiffness ☐ Joint discoloration ☐ Joint swelling
- ☐ Generalized weakness ☐ Joint pain ☐ Numbness/tingling
- ☐ Heaviness" of body/limbs ☐ Other:_____

**Skin:**

- ☐ Acne ☐ Dry skin ☐ Itchy skin
- ☐ Brittle/weak nails ☐ Eczema/psoriasis ☐ Night sweats
- ☐ Bruise easily ☐ Hives/Rashes ☐ Spontaneous sweat
- ☐ Changes in moles/lumps ☐ Other:_____

**Gastrointestinal:**

- ☐ Acid reflux/heartburn ☐ Blood in stool ☐ Intestinal pain/cramping
- ☐ Anal fissures ☐ Constipation ☐ Loose/soft stool
- ☐ Bad breath ☐ Gas ☐ Mucous in stool
- ☐ Black stool ☐ Hemorrhoids ☐ Nausea
- ☐ Bloating ☐ Hiccups ☐ Vomiting
- ☐ Other:_____

**Appetite/Thirst:**

Temp of drinks most commonly desired: □ Very cold □ Tepid □ Very Hot

- □ Exceedingly hungry
- □ No thirst
- □ Excessive thirst
- □ Poor appetite
- □ Hunger w/no desire to eat
- □ Thirst w/no desire to drink
- □ Other:_____

**Sleep:**

- □ Difficulty waking up
- □ Trouble staying asleep
- □ Sound/restful
- □ Vivid dreaming/nightmares
- □ Trouble falling asleep
- □ Wake easily
- □ # hours sleep/night: _____
- □ Other:_____

**Emotions:**

- □ Angry/Frustrated
- □ Fearful
- □ Manic
- □ Anxious
- □ Forgetful/poor memory
- □ Relaxed/calm
- □ Depressed/sad
- □ Impatient
- □ Stressed
- □ Other:_____

**General:**

- □ Always feel cold
- □ Cold hands/feet
- □ Fever& Chills
- □ Always feel hot
- □ Fatigue
- □ Recent unexplained weight changes
- □ Other:_____

**<u>MEN ONLY</u>: (please check all that apply)**

- □ Groin Pain
- □ Painful Urination
- □ Reduced Sexual Energy
- □ Impotence
- □ Premature Ejaculation
- □ Seminal Emission
- □ Infertility
- □ Prostate Problems
- □ Trouble With Urination
- □ Date of last prostate exam: _____