United Integrated
Healthcare Center

Women'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-pay and deduct are due in full at the time of service and UIHC will submit claims 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 any time.
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>WOMEN ONLY</u>: (please select yes or no)

KIDNEY YIN DEFICIENCY	**Yes**	**No**
Do you have low back weakness/soreness/pain, or knee problems?	□	□
Do you have ringing in your ears or dizziness?	□	□
Is your hair prematurely gray?	□	□
Do you have vaginal dryness?	□	□
Is your mid-cycle fertile cervical mucus scanty or missing?	□	□
Do you have dark circles around or under your eyes?	□	□
Do you have night sweats?	□	□
Are you prone to hot flashes?	□	□
Would you describe yourself as one who is often afraid?	□	□
Does your tongue lack coating? Does it appear shiny or peeled?	□	□

KIDNEY YANG DEFICIENCY	**Yes**	**No**
Do you have low back pain premenstrually?	□	□
Is your low back sore or weak?	□	□
Do you have cold feet; especially at night?	□	□
Are you typically colder than those around you?	□	□
Is your libido low?	□	□
Are you often fearful?	□	□
Do you wake up at night/early morning because you have to urinate?	□	□
Do you urinate frequently, and is the urine diluted and/or profuse?	□	□
Do you have early morning loose, urgent stools?	□	□
Do you have excess vaginal discharge?	□	□
Do you feel cold cramps during periods that respond to a heating pad?	□	□
Is you tongue pale, moist, and swollen?	□	□

SPLEEN QI DEFICIENCY	**Yes**	**No**
Are you fatigued?	□	□
Do you have a poor appetite?	□	□
Is your energy level lower after a meal?	□	□
Do you feel bloated after eating?	□	□
Do you crave sweets?	□	□
Do you have loose stools, abdominal pain, or digestive problems?	□	□
Are your hands and feet cold?	□	□

Is your nose cold?	□	□
Are you prone to feeling heavy or sluggish?	□	□
Are you feeling heaviness or grogginess in the head?	□	□
Do you bruise easily?	□	□
Do you think you have poor circulation?	□	□
Do you have varicose veins?	□	□
Are you lacking strength in your arms and legs?	□	□
Are you lacking in exercise?	□	□
Are you prone to worry?	□	□
Have you been diagnosed with low blood pressure?	□	□
Do you sweat a lot with minimal exertion?	□	□
Do you feel dizzy/light-headed, or have altered vision if you stand up too fast?	□	□
Is your menstruation thin, watery, profuse, or pinkish in color?	□	□
Are you more tired around ovulation and menstruation?	□	□
Do you ever spot a few days or more before your period comes?	□	□
Have you ever been diagnosed with uterine prolapse?	□	□
Are cramps accompanied by a bearing-down sensation in your uterus?	□	□
Are you often sick, or do you have allergies?	□	□
Have you been diagnosed with hypothyroid or anemia?	□	□
Do you have hemorrhoids or polyps?	□	□
Does your tongue look swollen with teeth marks on the sides?	□	□
Do you have a pale, yellowish complexion?	□	□

BLOOD DEFICIENCY	**Yes**	**No**
Are your menses scant and/or late?	□	□
Do you have dry, flaky skin?	□	□
Are you prone to getting chapped lips?	□	□
Are your fingernails or toenails brittle?	□	□
Are you losing the hair on your head (not patches, but all over)?	□	□
Is your hair brittle or dry?	□	□
Do you have diminished nighttime vision?	□	□
Do you get dizzy or light-headed around your period?	□	□
Are your lips, the inner side of your lower eyelids, or tongue pale in color?	□	□

BLOOD STASIS	**Yes**	**No**
Is your menstrual flow ever brown or black in color?	□	□
Do you feel mid-cycle pain around your ovaries?	□	□
Do you have painful, unmovable breast lumps?	□	□
Do you experience periodic numbness in your hands and feet?	□	□
Do you have varicose or spider veins?	□	□
Do you have red hemangiomas (cherry-red spots) on your skin?	□	□
Does your complexion appear dark and “sooty”?	□	□
Do you have chronic hemorrhoids?	□	□
Does your menstrual blood contain clots?	□	□
Have you been diagnosed with endometriosis or uterine fibroids?	□	□
Is your lower abdomen tender to palpation (resisting touch)?	□	□
Can you feel any abdominal lumps in your lower abdomen?	□	□
Do you have piercing or stabbing menstrual cramps?	□	□
Does your tongue look dark?	□	□
Do you have dark spots on your tongue?	□	□
Are the veins beneath your tongue twisty and tortuous?	□	□
Do you have dark spots in your eyes?	□	□
Do you have a vascular abnormality or blood clotting disorder?	□	□

LIVER QI STAGNATION	**Yes**	**No**
Are you prone to emotional depression?	□	□
Are you prone to anger and/or rage?	□	□
Do you become irritable premenstrually?	□	□
Do you feel bloated and irritable around ovulation?	□	□
Does it feel as if your ovulation lasts longer than it should?	□	□
Are your breasts sensitive/sore at ovulation?	□	□
Do you experience nipple pain or discharge from your nipples?	□	□

Have you been diagnosed with elevated prolactin levels?	□	□
Do you become bloated prior to menstruation?	□	□
Are your pupils dilated and large?	□	□
Do you have difficulty falling asleep at night?	□	□
Do you experience heartburn or wake up with a bitter taste in your mouth?	□	□
Are your menses painful?	□	□
Do you feel your menstrual cramps in the external genital area?	□	□
Is the menstrual blood thick and dark, or purplish in color?	□	□

HEART DEFICIENCY	**Yes**	**No**
Do you wake early and have trouble getting back to sleep?	□	□
Do you have heart palpitations, especially when anxious?	□	□
Do you have nightmares?	□	□
Do you seem low in spirit or lacking in vitality?	□	□
Are you prone to agitation or extreme restlessness?	□	□
Do you fidget?	□	□
Is the tip of your tongue red?	□	□
Is there a crack in the center of your tongue that extends to the tip?	□	□
Do you sweat excessively, especially on your chest?	□	□

EXCESS HEAT	**Yes**	**No**
Is your pulse rate rapid?	□	□
Are your mouth and throat usually dry?	□	□
Are you thirsty for cold drinks most of the time?	□	□
Do you often feel warmer than those around you?	□	□
Do you wake up sweating or have hot flashes?	□	□
Do you break out with red acne (especially pre-menstrual)?	□	□
Do you have a short menstrual cycle?	□	□
Do you have vaginal irritation or rashes?	□	□

DAMPNESS	**Yes**	**No**
Do you feel tired and sluggish after a meal?	□	□
Do you have fibrocystic breasts?	□	□
Do you have cystic or pustular acne?	□	□
Do you have urgent, bright, or foul-smelling stools?	□	□
Does your menstrual blood contain stringy tissue or mucus?	□	□
Are you prone to yeast infections and vaginal itching?	□	□
Do your joints ache, especially with movement?	□	□
Are you overweight?	□	□
Do you have a wet slimy tongue?	□	□

DAMP HEAT	**Yes**	**No**
Do you have foul-smelling, yellow, or greenish vaginal discharge?	□	□
Do you have vaginal or rectal itching during luteal or premenstrual phase?	□	□

COLD UTERUS	**Yes**	**No**
Do you fit the Kidney Yang deficiency category?	□	□
Do you fall into the Blood Stasis pattern?	□	□
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	□	□