Community Acupuncture Clinic of Vero Beach Intake Form

Name:
DOB: Marital Status:

Address:

City: State Zip

Phone Number:

E-mail address:
Place of Employment:

Body Temperature wise I tend to be:
Warmer Cooler
I prefer drinking:
Warm beverages Cool beverages
My digestion is:
Fantastic OK Poor Needs help
Amount of times I move my bowels per day:
5 4 3 2 1 Less than 1
My diet is closer to:
Fast and processed food
Protein and starch
Protein and vegetables, plus starch
Protein and vegetables
Vegetarian
Lactovegetarian
Vegetarian plus fermented foods
Raw foods
I sleep well I do not sleep well
My energy is good I have fatigue
Questions for women:
I still menstruate I no longer menstruate
My cycle is:
Regular Irregular
Characteristics of my cycle:
Abdominal cramping Back pain
Food cravings Crying
Desire to be alone Irritability
My flow is:
Profuse Light
Bright red Dark
If I NO longer menstruate, it is because:
Surgery Menopause
Date Date
I still have menopausal symptoms:
Yes No
Question for men:
I do do not have problems urinating

The main reason for my visit is:

CONSENT FOR ORIENTAL MEDICINE

Scope of Practice

The "scope of practice" for an acupuncturist in the state of Florida includes but is not limited to the following list of techniques:

- Use of acupuncture needles to stimulate acupuncture points and meridians
- Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridian
- Acupressure
- Laserpuncture
- Dietary advice based on traditional Chinese medical theory

I recognize the potential risks/side effects and benefits of these procedures as described below:

Potential risks/side effects may include, but are not limited to the following:

- Pain following treatment in insertion area
- Temporary discoloration of the skin
- Aggravation of symptoms existing PRIOR to the treatment
- Minor bruising
- Broken needle
- Infection
- Needle sickness

NOTE: Patients with bleeding disorder, pacemakers, seizure disorders, or women who are currently pregnant, PLEASE notify the practitioner.

Potential benefits may include, but are not limited to the following:

- Drugless relief of presenting symptoms
- Improved general health
- Elimination of the presenting problem
- Reduction of pain and associated symptoms

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Community Acupuncture of Vero Beach, regarding cure or improvement of my condition. I hereby release Community Acupuncture of Vero Beach from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care.

In signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally in signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in payment of this claim.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time

PATIENT/GUARDIAN SIGNATURE DATE

Health history continue

Check symptoms you have had in the **last 3 months**

- Depression
- Difficulty in focusing
- Dizziness
- Easily startled
- Excessive worry
- Excessive fear
- Overwhelmed by life
- Fatigue/tiredness
- Headaches
- Loss or gain of weight
- Nervousness/irritability

Check conditions you have or have had in the past:

- AIDS
- Allergies
- Anemia
- Arthritis
- Bleeding disorders
- Breast lump
- Cancer
- Diabetes
- Hepatitis/liver disease
- How long has it been since you have had a complete medical exam?_____

MUSCLE/JOINT BONE

- Tremors
- Swollen joints

Pain weakness or numbness in:

- Arms
- Back/hips
- Legs
- Feet
- Neck
- Shoulders
- Other_____

EYES/EARS/NOSE/THROAT/RESPIRATORY

- Asthma
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin

SKIN CONT'D

- Sensitive skin
- Sore(s) that will not heal
- Sweats
- Other_____

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infections
- Lowered libido
- Other_____

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankle
- Other_____

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall Bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Other_____

List medications you are currently taking:

_____

_____

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_____

_____

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_____

The information on this form is correct to the best of my knowledge.

_____

PATIENT/GUARDIAN SIGNATURE DATE