Body Mind Spirit

Date of Initial Visit _____

Patient Information

Patient's Name:

_____ Gender (circle one): Male Female

Date of Birth _____

Age _____ How did you hear about us?_____

Mailing Address _____ Is this your first experience of Acupuncture? _____

_____ Are you currently pregnant or Considering? _____

C/Tel _____ H/Tel _____ W/Tel _____

Email _____

Single □ Married □ Divorced □ Widowed □ Domestic partnership □ Other

Primary Care/Referring Physician: Emergency Contact Person / Telephone

_____ _____

Address _____

Telephone_____

_____

What would you like treated with acupuncture? _____

How Long have you had this condition? _____onset was ❍ sudden ❍ gradual

Symptoms are relieved or worsened by _____

Medical Diagnosis for this condition?_____

Treatments you have already had for this condition? _____

Please List Medications, Drugs Vitamins Herbs

□ Aspirin □ Antacids □ Blood thinners □ Sleeping pills □ Ibuprofen
□ Fiber/Laxatives □ Blood pressure pills □ Tranquilizers □ Acetaminophen (Tylenol)
□ Diet pills □ Insulin □ Anti-depressants □ Oral contraceptives
□ Allergy medication □ cholesterol Meds

Please complete this information accurately so we are able to assist you properly in your healing process

Please Note that all information provided on this form is confidential

Body Mind Spirit Debora Silverman, Lac 728 Bryant Street San Francisco, CA 94107 T/415 882 9988

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Past medical history: *please check any conditions that apply*

How was your childhood health?_____

Please list any hospitalizations or surgeries _____

How many caffeinated drinks do you drink weekly – coffee, tea, soda? _____

Aids/hiv	Alcoholism	Thyroid Disorder
Asthma/Allergies	Birth trauma	Cancer
Diabetes	Drug addictions	Emphysema
Facial work i.e. botox, collagen, surgery	Fibromyalgia	Heart disease
Hepatitis a/b/c	Herpes	Joint replacement
Lyme Disease	Lymph Removal	Multiple Sclerosis
Pacemaker	Polio	Rheumatic Fever
Scarlet Fever	Pneumonia	Seizures
Sinus infections	Tuberculosis	Operations/Hospitalizations
Mononucleosis	Headaches/Migranes	High Blood Pressure

	AGE (if deceased, age at time of death)
Mother	
Father	
Siblings	M F
Children	M F
Family incidence:	
Hypertension / Cardiac Disease	
Diabetes Melitis	
Cancer	
Stroke / CVA	
Arthritis	
Seizures	
Depression / Mental Illness	
Asthma/Allergies	
Blood Disorder	
Alcohol / Substance Abuse	
Headache / Migraine	
Others (list):	

Please check any habits which apply to you now or in the past

Coffee	Yes □	No □	per day/week ____	age started ____	age quit ____
Tobacco	Yes □	No □	per day/week ____	age started ____	age quit ____
Alcohol	Yes □	No □	per day/week ____	age started ____	age quit ____
Crack	Yes □	No □	per day/week ____	age started ____	age quit ____
Cocaine	Yes □	No □	per day/week ____	age started ____	age quit ____
Heroin	Yes □	No □	per day/week ____	age started ____	age quit ____
Marijuana	Yes □	No □	per day/week ____	age started ____	age quit ____

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Exercise & Energy

How is your energy?_____Do you fatigue easily?_____

What kind of exercise and how often do you practice?_____

Emotion & Sleep

How do you feel emotionally?_____

Do you have (please circle) panic attacks depression anxiety bad temper nervousness fear attacks poor memory

Are you married or in a relationship? _____

How many hours do you normally sleep? _____

I have difficulties (please circle) falling asleep staying asleep dream disturbed sleep waking up at..... am/pm

Digestive

I have (please circle) belching nausea vomiting vomiting blood ulcers bloating acid regurgitation heartburn hernia indigestion stomach pain stomach gurgling

Bowel movements – how often? .....times daily.....days/week

I have (please circle) irregular bowel movements constipation diarrhea alternating gas burning sensation Hemorrhoids undigested food in stool loose stool hard stool blood in stool itchiness painful movements

Urination

I have (please circle) normal pale yellow dark yellow blood in urine frequent urination incontinence pain Burning urination nocturnal urination.....times dribbling when sneezing kidney stones UTI

Women

At what age did you begin menstruation?_____Number of days between cycles?_____

Number of days of flow?_____Color? Bright red/dark red/pale/brown/rust/purple red/other

Do you practice birth control?_____What type/how long have you been taking it? _____

Pregnant? yes/no I have (please circle) Irregular menses heavy flow light flow no flow clots vaginal itching vaginal burning spotting between cycles pain before menses /pain during menses PMS

Vaginal discharge?_____Frequent?_____Color?_____odor?_____

Men

I have (please circle)

Prostatitis impotence penis - blood/mucous discharge swollen testes testicular pain premature ejaculation cold/numbness in external genitalia other

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Muscles joints & bones

Do you experience pain or tightness?_____where?_____

The pain is (please circle)

Sharp dull aching numb superficial pain deep pain burning tingling shooting pain worse/better heat

Pain worse /better cold pain worse/better pressure pain worse in.....AM / PM

I have (please circle) swollen joints arthritis/joint pain tendonitis bone pain muscle cramping muscle pain

repetitive strain injury fractured bone where?

Eyes, ears nose, throat & head

Do you smoke?_____how many per day?_____how many years?_____

I have (please circle)

Frequent colds chronic runny nose frequent sore throat chronic cough coughing blood coughing up

Mucous Pain inhaling Pain Exhaling shortness of breath.....on exertion / on rest asthma nose bleeds

painful red eyes poor vision Spots / floaters dizziness cold sores bleeding gums dry mouth ear pain

ringing in ears clogged/popping ears

Frequent headaches/migranes?_____what location of the head?_____describe?_____

Cardiovascular

I have (please circle)

Chest pain palpitation varicose veins phlebitis cold hands/feet irregular heart beat other

Skin & hair

I have (please circle) Dry skin rashes itching acne eczema hives hair loss premature

Graying

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Informed Consent for Acupuncture Treatment and Care

Oriental Medical Treatments may include, but are not limited to : acupuncture, moxibustion, cupping, electrical stimulation, herbal medicine, massage and nutritional counseling. These treatment methods have the effect of normalizing physiological functions and treating dysfunctions of the body.

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 needling site that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this office maintains a clean, safe environment, and only sterile, disposable needles are used. Bruising is a common side effect of cupping. Burns and/or scarring are a potential risk of moxibustion. 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 are recommended are traditionally considered safe in the practice of Oriental Medicine. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be prepared and consumed according to the instructions provided. I will immediately notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of my herbal prescription. I also know that these herbs were prepared specifically for my health needs and should not be shared with others.

I understand that some herbs and acupuncture treatments may be contraindicated during pregnancy. I agree to notify my practitioner if I am or become pregnant.

I understand that the clinical staff may review my records

Financial Agreement

You are financially responsible for all services rendered to you in this office. Payment is made in full (100%) for each visit at the time of visit unless special arrangements have been made with your provider.

Cancellation Policy

We have reserved your appointment time just for you. If you need to reschedule please be sure to call the office at least 24 hours before your scheduled appointment so we can make your time available to another client. No charge will be made for cancellations or appointment changes if 24 hours notice is given. For cancellations with less than 24 hours you will be charged the full fee.

Client Signature _____ Date _____

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