

Confidential intake for Tao to Wellness

510.883.0383

Name: _____ Sex: M F Age: _____ Today's Date: _____

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

Phone #: _____ Birth Date: _____ Email: _____

Would you like to receive occasional emails with specials, newsletters and/or announcements? Yes No

Occupation: _____ Referred by: _____

Have you ever had acupuncture before? Yes No

In case of emergency, call: _____ Telephone _____

Acupuncture Examination

Note: This is a confidential record of your medical history and will be kept in our possession.
Information contained here will not be released to any person without your authorization.

Circle if you have been diagnosed with any of the following:

- | | | |
|----------------------------------|----------------------|----------------------|
| Anemia | Gall Stones | Osteoarthritis |
| Asthma | Heart Issues | Ovarian cyst |
| Bleeding Disorders | Hepatitis | PCOS |
| Bronchitis | Hernia | Prostatitis |
| Cancer | HIV/AIDS | Pneumonia |
| Candida | High Blood Pressure | Rheumatoid Arthritis |
| Chronic Urinary Tract Infections | High Cholesterol | Scoliosis |
| Diabetes | Hyperthyroidism | Stroke |
| Epilepsy | Hypothyroidism | Tuberculosis |
| Epstein Barr Virus | Irritable Bowel Syn. | Tumors |
| Fibromyalgia | Kidney Stones | |
| Fibroid Tumor | | |

What is the goal of your visit? _____

If your problem is related to pain: Yes No If Yes, list location(s): _____

On a scale of 1-10 (1: no pain 10: excruciating pain) what is your pain level typically? _____

What is your pain level today? _____

Please check if you experience the following symptoms: Yes No Sometimes

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Frequent Colds or Flu | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue/Lethargy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Generalized muscle pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stiffness in your joints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dry or sore throat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Yeast infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Flatulence / Excessive Gas /Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Acid reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Ulcers/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bitter / Sour taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck & shoulder tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clench your jaw / Grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands and / or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stressful Dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression or Sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything else you'd like us to know about your health?: _____

For Women only:

Please check if you experience the following symptoms: Yes No Sometimes

Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PMS breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What was the start date of your last menstrual period? _____ Are you Pregnant? Yes No Maybe

During your period does your menstrual stop for a day and restart the following? Yes No

For women starting or in menopause: Are you still having periods? Yes No

Please check if you experience the following symptoms: Yes No Sometimes

Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial Flushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INFORMED CONSENT FOR CHINESE MEDICAL TREATMENT

I hereby request and consent to the performance of acupuncture and other procedures within the scope of practice of Traditional Chinese Medicine on myself (or the patient named below for whom I am legally responsible for) by Christina Martin L.Ac., Kara Sorensen, L.Ac. and/or any other licensed acupuncturists serving as back-up for the Tao to Wellness acupuncturists.

I understand and have been informed that, as in the practice of acupuncture, there are some risks to treatment, including but not limited to possible bruising, possible hematoma, residual soreness, nausea or infection.

I am also aware that this is a community acupuncture setting, and not a private session. If my concerns require a more thorough evaluation or if confidentiality is a concern, I may request a more detailed intake and/or private session(s).

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by the patient: To be completed by patient's representative or guardian:

Print Name	Print Name of Patient	Relationship to Patient
Signature of Patient	Print Name of Representative	Date
Date	Signature of Representative	

CANCELLATION and PAYMENT POLICY

In order to maintain the integrity of our practice, we ask that all cancellations be made with a minimum of 24 hours notice via our website. Failure to provide 24-hour notice will result in a charge of \$25.00, failure to show or call will result in a charge of \$40.00. If you sign below, you will be held responsible for these charges.

We require payment after services are rendered. We only accept CASH for Community Acupuncture.

Please sign _____