COTATI COMMUNITY ACUPUNCTURE

315 E. Cotati Ave, Suite E
Cotati, CA 94931
707-242-6812

Initial Intake Questionnaire
Holistic Health Assessment

Important: This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible, even if you do not feel certain questions pertain to your present condition. Thank you.

Name:_____ Gender: M F Date:_____

Home Address:_____ City:_____

State:_____ Zip:_____ Email:_____

Birth date:_____ Age:_____ If under 18, person responsible for your account:_____

Home phone:_____ Work phone:_____ Cell phone: _____

Emergency Contact: Name:_____ Contact phone:_____

Marital Status: _____single _____married _____divorced _____widowed _____with a significant other

Are you a caregiver for dependents? Yes No If yes, how many children?_____ How many adults_____

Occupation:_____ Number of years in this type of work:_____

Retired: Number of years in retirement:_____ Occupation when in workforce *(please fill out the previous line)*

Primary care physician: Name:_____ Phone:_____

How did you hear about us? *Please circle one and write the name*

Current patient:_____ Friend:_____

Doctor:_____ Insurance:_____

Advertisement:_____ Other:_____

Have you had acupuncture before? Yes No If yes, with whom?_____ When_____

For what condition?_____

Please indicate if any of the following pertain to you: (indicating "yes" does not make you ineligible for treatment, however, it may restrict some of your treatment modalities)

____hepatitis ____HIV ____high blood pressure ____seizures ____pacemaker ____blood-thinning meds

___pregnancy ____Surgically implanted joint/bone replacement or stabilizers

Current Health Concerns

Please list your health concerns in order of priority:

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____

Are you currently under the care of any other health care provider (physician, chiropractor, therapist, massage therapist, etc.)? Yes No

If yes, please provide the name and title of the practitioner(s), the condition being treated and the length of time you have been receiving this treatment:

Practitioner Condition Length of treatment to present

_____

_____

_____

Please list all past medical conditions for which you were hospitalized and/or received surgery (include the dates).

_____

_____

_____

Habits and Lifestyle

Do you smoke?_____ If yes, what?_____ How much per day?_____ Since when?_____

Do you drink alcohol?_____ If yes, what?_____ How much?_____ How often?_____

Do you exercise regularly?_____ If yes, please describe what you do:_____

Emotional stress scale *Please circle*

1	2	3	4	5	6	7	8	9	10
No Stress				Moderate					Extremely stressed

Nutrition

Do you drink coffee?_____ If yes, how much per day?_____

Do you drink caffeinated tea?_____ If yes, how much per day?_____

Do you drink soda pop? regular diet none *(Please circle one)* If yes, for how long?_____

Do you have regular eating habits? Yes No

Do you eat while engaged in other occupations? Yes No

Do you eat more when under stress or feeling depressed? Yes No

Do you experience sudden drops in energy? Yes No If yes, when?_____

Please describe a typical day's diet for you:

Breakfast	Lunch	Dinner	Snacks(what hour?)

WOMEN ONLY *please circle response as appropriate*

Are you currently experiencing any gynecological symptoms or problems? Yes No
Are you currently sexually active? Yes No If yes, partner(s) is/are male female
If sexually active, do you perform safe sex practices? Yes No
Any problems related to sexual function? Yes No
Do you have any history of sexually transmitted diseases? Yes No
Do you have any history of cervical, ovarian, or breast cancer? Yes No
Do you perform regular breast self-exams? Yes No
How old were you at onset of first menses?_____
If you are of menstruating age: date of last period_____
periods generally last_____days and occur every_____days
bleeding is _____heavy _____moderate _____light
List any PMS symptoms:_____
_____

If you are menopausal or perimenopausal:
Are you taking hormone replacement therapy? Yes No
List and symptoms or concerns:_____
_____
Number of pregnancies and your age at each_____
Number of live births and your age at each:_____
Natural deliveries?_____ C-sections?_____
Are you currently trying to conceive? Yes No

MEN ONLY *please circle response as appropriate*
Are you currently sexually active? Yes No If yes, partner(s) is/are male female
If sexually active, do you perform safe sex practices? Yes No
Do you have any history of sexually transmitted diseases? Yes No
Have you ever had a diagnosis of prostate enlargement or cancer? Yes No
Do you ever experience trouble with urination (frequency, hesitancy, pain, dribbling)? Yes No
Do you ever experience trouble with sexual function/libido? Yes No

Medications/Supplements

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them.

Medications----------	Reasons----------	Date Began-----	Dose-----	Helps Yes or No
Supplements	Reason	Date Began	Dose	Helps Yes or No

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Signature_____ Date_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of massage and/or acupuncture treatments and other procedures within the scope of practice of massage and/or acupuncture on me (or on the patient named below, for whom I am legally responsible) by the massage practitioner or acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the health care provider named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to Tui-Na medical massage, acupressure or acupuncture, moxibustion, cupping, electrical stimulation, Asian herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant side effects associated with the consumption of herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and Gua-Sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE
(Or Patient Representative) **X** (Date)

(Indicate relationship if signing for patient)