Lynne Omenson, LAc.

Acupuncture Intake Form

This information is confidential *Date:* _____

Name: _____ *Age:* _____
*Address:*_____ *Sex: M / F*
City: _____ *State:* _____ *Zip Code:* _____
Phone number: _____
Birth Date: _____
Occupation: _____
Physician: _____ *Physician Phone #:* _____

Have you ever had acupuncture? Y / N

What is your current complaint? _____
_____*How long?* _____

What other treatments have you tried? _____
_____

Medications you are currently taking: *For what conditions:*
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medical History (Check all that apply)

__*Aids/HIV*
__*Allergies to Latex*
__*Cancer*
__*Emphysema*
__*Diabetes*
__*Heart Disease*
__*Seizures*
__*Tuberculosis*
__*Alcoholism/Substance Abuse*
__*Hepatitis A / B / C*
__*Herpes*
__*Lyme Disease*
__*Multiple Sclerosis*
__*Pacemaker*
__*Polio*
__*Varicose Veins*

Surgeries: _____
Food Cravings? _____
Food Intolerances? _____
How many glasses do you drink each day of the following per day?
Water _____*Soda* _____*Coffee* _____*Tea* _____*Alcohol* _____

Do you perspire during the day? _____
Do you perspire at night? _____
Are you always thirsty? Yes / No
*Do you prefer drinks that are Hot or Cold?*_____
Taste preferences on a scale of 1 to 5, 1 being most liked to 5 disliked:
____*Salty* ____*Sour* ____*Bitter* ____*Sweet* ____*Spicy*

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Gastrointestinal:

Do you have currently or have you had a major incidence in the past?

____Belching ____Indigestion ____Ulcers
____Hernia ____Nausea ____Vomiting
____Bloating ____Acid Reflux ____Hemorrhoids

Bowel movements: How often? _____day/week
_____Irregularity _____Constipation _____Diarrhea _____Gas

Exercise and Energy:

What kind of exercise do you do? _____How often? _____
How is your general energy level?_____
Are you sedentary or active? _____

Emotions and Sleep:

____Panic Attacks ____Depression ____Anxiety ____Difficulty Concentrating
____Nervous ____Fearful ____Poor Memory

Do you take antidepressants?_____ What kind? _____
Do you take sleeping pills? _____What kind? _____
Difficulty falling asleep _____Restless_____Disturbed Sleep _____
Dreams_____Waking up in the night_____

Urination:

How many times a day_____Light or Dark in Color _____Bladder Infections _____
Frequent Urination? _____Incontinence _____Burning _____
Do you wake up at night to urinate? _____ Pain during urination? _____

Gynecology:

Are you still menstruating? _
____Heavy flow ____Light flow ____No flow
____Blood clots ____PMS ____Painful periods
____Uterine fibroids ____Cystic breasts

Respiratory:

Do you smoke? Y / N _____times /day for _____years
____Frequent Colds ____Asthma ____Cough ____Cold Sores
____Bleeding Gums ____Dry mouth ____Ear pain ____Migraine
____Ringing in Ears ____Sinusitis ____Excessive Phlegm

Cardiovascular:

____Palpitations ____Varicose Veins ____Cold hands/feet
____Poor circulation ____Dizziness ____Chest pain
____Irregular heart beat ____High blood pressure ____Low blood pressure
____Blood clots

Skin and Hair:

____Dry skin ____Skin rashes ____Itching
____Acne ____Eczema ____Hair loss

Musculoskeletal:

____Joint pain ____Arthritis ____Muscle tightness ____Numbness
____Tendonitis ____Osteoporosis ____Swelling

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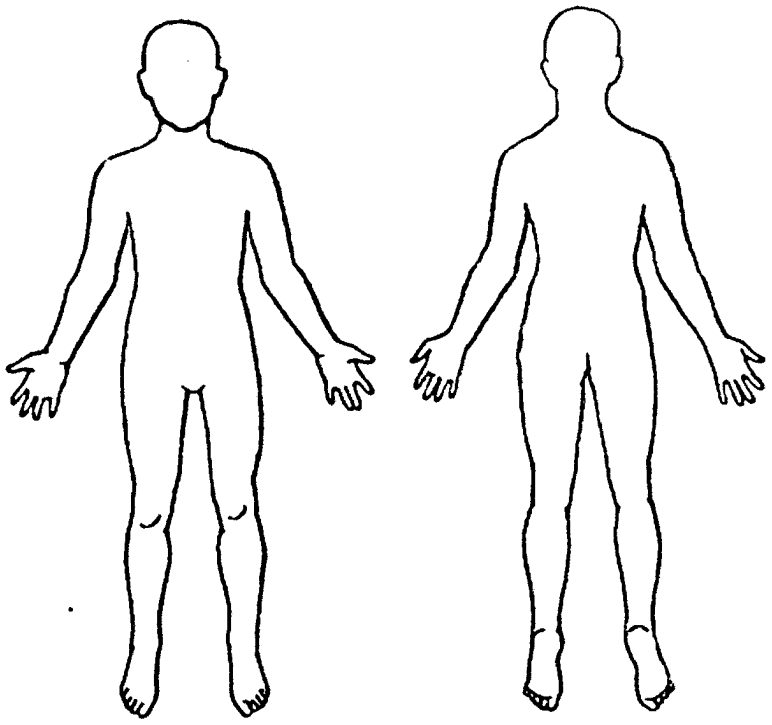
*Where is the general area that you are feeling any discomfort?*_____

Chronic or Acute?

What number best describes your pain now?
No pain 1 2 3 4 5 6 7 8 9 10 Worst pain

Mark with an (X) where you are feeling any discomfort or pain.



If pain, please describe: Sharp Dull Stabbing (please circle)

What makes the pain better? (circle all that apply)
heat cold movement massage rest

*Do you have any additional health conditions?*_____
_____
_____
_____

Print Name _____

Patient Signature _____

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ACUPUNCTURE INFORMED CONSENT

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of:

Electro-acupuncture - using very small amounts of electricity to stimulate specific acupuncture points.

Cupping - glass or plastic cups are placed on the skin with a vacuum created by heat or suction.

Moxibustion - the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations.

Liniments, Essential Oils, Plasters – Herbal or medicinal formulas applied topically to the skin.

Acupressure, Massage, and Manual Therapy – The use of Traditional Chinese Medicine massage and therapeutic bodywork.

Potential Benefits: Drugless relief of presenting symptoms and improved balance of body energies that may lead to prevention, improvement or elimination of the presenting problem.

Potential Risks: Discomfort, pain, bruising, blistering, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment.

Patients with bleeding disorders or pacemakers should inform the L. Ac. Prior to receiving treatment.

"With this knowledge, I voluntarily consent to the above procedures."

Printed Name Date

Signature of Patient Date