Initial Session Intake Form

Welcome to the Healing Blossom!

the healing blossom
ACUPUNCTURE & WELLNESS

PATIENT INFORMATION

Name

Address

City/State Zip

☐ It is okay to mail items to this address

Home Phone

Mobile Phone

Work Phone

Best way to contact: ☐ Home ☐ Mobile ☐ Work

☐ It is okay to leave a detailed message at this number

Email Address

Birth Date (MM/DD/YYYY)

Gender: ☐ Female ☐ Male

Insurance

Employer

Occupation

Primary Care Doctor

Address

Phone

How did you hear about the Healing Blossom?

EMERGENCY CONTACT

Name

Relation

Home Phone

Mobile Phone

GENERAL INFORMATION

Have you tried acupuncture before? ☐ Yes ☐ No

Has someone you know had success with acupuncture? ☐ Yes ☐ No

Please list top three areas of concern regarding your visit today?

1.

2.

3.

Please list the medications you are taking and what you take them for:

Please list the supplements you are taking and what you take them for:

Please list any dietary restrictions and/or any special diets you are on (i.e. low sodium, vegetarian, etc.):

Blood type

Medical diagnoses you have been given (i.e. diabetes, carpal tunnel, broken bones, etc.)

CURRENT CONDITION

What is the primary reason for your visit today?

When did the problem(s) begin?

Is this the result of an injury or accident?

Have you seen a physician or other medical personnel?

How long have you had this condition?

What makes it feel better?

What makes it feel worse?

What therapies have you tried in the past?

What other therapies are you currently receiving?

Please select any issues you are experiencing:

GENERAL:

- ☐ Poor appetite
- ☐ Gas/bloating
- ☐ Weight gain
- ☐ Poor sleep
- ☐ Feeling hot
- ☐ Strong thirst
- ☐ Stress
- ☐ Sudden energy drop
- ☐ Easy to bleed/bruise
- ☐ Weight loss
- ☐ Night sweats
- ☐ Feeling cold
- ☐ Chills or fever
- ☐ Other: _____
- ☐ Fatigue
- ☐ Food cravings
- ☐ Change in appetite
- ☐ Sweat easily
- ☐ Cold hands/feet
- ☐ Swelling in legs

HEAD, EARS:

- ☐ None
- ☐ Ringing in ears
- ☐ Sound of water rushing
- ☐ Sound of crickets
- ☐ Ear aches
- ☐ Other: _____
- ☐ Hearing loss
- ☐ Migraines
- ☐ Poor balance
- ☐ Dizziness
- ☐ Concussions
- ☐ Frequent headaches
- ☐ Facial pain
- ☐ Facial drooping
- ☐ TMJ pain

EYES, NOSE, THROAT:

- ☐ None
- ☐ Sore throat
- ☐ Sinus problems
- ☐ Frequent nose bleeds
- ☐ Toothache
- ☐ Watery eyes
- ☐ Allergies
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Blurry vision
- ☐ Floaters in vision
- ☐ Other: _____
- ☐ Cataract(s)
- ☐ Eye strain
- ☐ Night blindness
- ☐ Lip or tongue sores
- ☐ Taste/smell problems

CURRENT CONDITION CONTINUED

SKIN, HAIR:

☐ None ☐ Eczema ☐ Dandruff
☐ Itching ☐ Acne ☐ Graying early
☐ Wounds slow to heal ☐ Recent moles ☐ Dry/brittle hair
☐ Hives ☐ Dry skin ☐ Hair loss
☐ Rash ☐ Other: _____

GYNECOLOGY: (women only)

☐ None ☐ Excessive bleeding ☐ Frequent yeast infections
☐ Frequent UTIs ☐ Painful periods ☐ Irritability
☐ Vaginal discharge ☐ Blood clots ☐ PMS
☐ Cancer: _____ ☐ Dark color blood ☐ Breast lumps
☐ Fertility problems ☐ Post menopause
☐ Other: _____

How old were you when menses started? _____ Date of your last period: _____

How many days does your period last? _____ How many days between periods? _____

How many pregnancies have you experienced? _____ How many births? _____

UROLOGY:

☐ None ☐ Frequent urination ☐ Urinary incontinence
☐ Painful urination ☐ Blood in urine ☐ Decreased flow/pressure
☐ Cloudy urine ☐ Kidney stones ☐ Frequent night urination
☐ Urgency to urinate ☐ Other: _____

NEUROLOGICAL:

☐ None ☐ Tremors ☐ Mood swings
☐ Twitches ☐ Concussions ☐ Depression
☐ Irritability ☐ Lack of coordination ☐ Anxiety
☐ Fainting ☐ Areas of numbness ☐ Poor memory
☐ Loss of balance ☐ Seizures
☐ Other: _____

HEADACHES:

☐ None ☐ Behind eyes ☐ Worsen with stress
☐ Sinus headache ☐ Constant ☐ Head feels heavy
☐ Frontal headache ☐ Occasional ☐ Sharp/stabbing pain
☐ Right-/left-sided ☐ Causes visual problems ☐ Interferes with life routines
☐ Temples ☐ Migraines
☐ Other: _____

When did they begin? _____

How long do they last? _____

CURRENT CONDITION CONTINUED

ENERGY:

- ☐ Regular
- ☐ Nervous energy
- ☐ Hyper energy
- ☐ Fatigue
- ☐ Low
- ☐ Exhausted
- ☐ Always tired at certain time
- ☐ Better in morning
- ☐ Better at night

BOWEL MOVEMENTS:

- ☐ Well-formed, daily
- ☐ Constipation
- ☐ Hard and dry
- ☐ Incomplete
- ☐ Diarrhea
- ☐ Watery
- ☐ Loose
- ☐ Soft
- ☐ Black
- ☐ With mucous
- ☐ With blood
- ☐ Hemorrhoids

Number of bowel movements per day: _____

ABDOMINAL PAIN:

- ☐ None
- ☐ Occurs after eating
- ☐ Better after bowel movement
- ☐ Constant
- ☐ Bloating
- ☐ Distention of abdomen
- ☐ Pain/cramping
- ☐ Better after antacids
- ☐ Diagnosed ulcers
- ☐ Occurs when hungry
- ☐ Better after gas release
- ☐ Stabbing pain
- ☐ Other: _____

RESPIRATORY:

- ☐ None
- ☐ Yellow sputum
- ☐ Nose bleeds
- ☐ Spitting blood
- ☐ Chronic cough
- ☐ Snoring
- ☐ Bronchitis
- ☐ Frequent colds/flu
- ☐ Allergies
- ☐ Asthma
- ☐ Congestion
- ☐ Hoarseness
- ☐ Sinus infection
- ☐ Other: _____

CARDIO-VASCULAR:

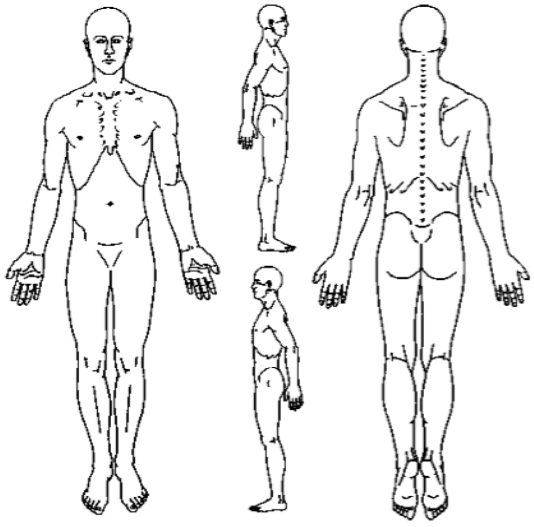
- ☐ Normal blood pressure
- ☐ Congenital heart condition
- ☐ Varicose veins
- ☐ Palpitations
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Ankle swelling
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ On heart medication
- ☐ Other: _____

MUSCULO-SKELETAL:

- ☐ None
- ☐ Scoliosis
- ☐ Low back pain
- ☐ Knee pain
- ☐ Athletic injury
- ☐ Unknown cause of pain
- ☐ Pain from injury
- ☐ Muscle spasm
- ☐ Muscle weakness
- ☐ Muscle cramping
- ☐ Pain in legs after walking
- ☐ Other: _____
- ☐ Arthritis
- ☐ Joint pain
- ☐ Joint weakness
- ☐ Pain with weather change
- ☐ Pain interfering with sleep

CURRENT CONDITION CONTINUED

Please notate area(s) of pain on the diagram below:



MEDICAL HISTORY

Type of Surgery(ies):

Date

Date

Date

Date

Type of Lab Test(s)

Date

Date

Result(s)

X-Ray

MRI

CT (CAT) Scan

Ultrasound

Cholesterol

Blood pressure

Blood sugar

Other blood work

Pap smear

Other

ADDITIONAL INFORMATION

Describe your regular exercise activities below:

	hours/day	days/week
	hours/day	days/week
	hours/day	days/week

Daily activities:

Sitting hours/day _____ days/week _____

Standing hours/day _____ days/week _____

Heavy labor hours/day _____ days/week _____

Describe: _____

Light labor hours/day _____ days/week _____

Describe: _____

Please rate your stress level on a scale of 0 (no stress) to 10 (highly stressed): _____

Tobacco use: Type: _____ Packs per day: _____ Number of years: _____

Alcohol use: Type: _____ Drinks per week: _____

Caffeine intake: Coffee cups per day: _____ Soda drinks per day: _____

Other: _____

Do you consider your weight to be: ☐ Normal ☐ Overweight ☐ Underweight

Height: _____ Weight: _____

Describe what you usually eat:

Breakfast

Lunch

Dinner

Snacks

Describe any other information that might be useful:

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible). I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Qi gong, Chinese herbal medicine, and nutritional counseling. 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 sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. 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, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese 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 immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist 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 office medical and administrative staff may review my medical 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, this 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name _____ Are you pregnant? _____

Patient's Signature_____ Date Signed _____

Name of Acupuncturist: Katie Hamilton
Performing acupuncture for: The Healing Blossom Acupuncture & Wellness Center

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient _____

Print Name of Patient Representative _____

Signature of Patient Representative _____ Date_____

Relationship or Authority of Patient _____

Financial Policy

1. ***The Healing Blossom Acupuncture & Wellness Center*** accepts cash, checks, or credit card.

2. **Cancellation policy:**
   a. If a client cancels at least 24 hours prior to the appointment, there is no charge.
   b. **If a client cancels less than 24 hours prior to the appointment or does not show, the client will be charged a fee of $90.**

3. Late Policy: We strive to give you our fullest attention during your allotted time. Your respect of other clients' time is appreciated and sessions will end promptly as scheduled. Late arrivals are responsible for the full fee of the session.

_____ Please initial that you have read and understand our cancellation policy

Fee Structure:

30-minute consultation = free

First visit with consultation and treatment (90 minutes) = $145

Individual follow-up appointment (60 minutes) = $90

Facial rejuvenation treatments (90 minutes) = $155