



## Men's Acupuncture Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Sex: M F Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  Single  Married  Divorced  Widowed  Separated

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### RESPONSIBILITY AGREEMENT WITH CONSENT TO TREATMENT AND STATEMENT OF FINANCIAL POLICY

**By signing below you acknowledge, understand and agree to the following:**

1. I am responsible for payment for all services rendered - payment due in full at the time of service. Take 2 Healthcare Center will provide a receipt for me to submit to my insurance company.
2. I understand that unless 24 hours advanced notice is given, I am financially responsible for cancelled or missed appointments.
3. I hereby consent to acupuncture and related holistic treatments and evaluations rendered to me (or my child if a minor) by Dr. Ashley N. Marchek DC or Dr. Andrew Dyer, DC. I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time.
4. Acupuncture is a healing therapy involving the insertion of fine needles into specific points along meridians on the body. In addition to the use of needles, the scope of acupuncture includes the use of electrical, mechanical or magnetic devices to stimulate acupuncture points, moxibustion, acupressure, cupping and/or infra-red therapy.
5. Acupuncture side effects may include some pain following treatment in the insertion area, temporary aggravation of symptoms existing prior to treatment, minor bruising, slight bleeding, dizziness, infection or needle sickness (fainting).
6. **If you are pregnant, taking anti-coagulant drugs (Coumadin), have a bleeding disorder, diabetes, heart condition, circulatory problems, blood clots, blood borne disease such as HIV or Hepatitis, cancer/malignancies, bone disorders, metal implants or have a pacemaker you should make that information known to Dr. Ashley Marchek DC or Dr. Andrew Dyer, DC prior to treatment.**
7. Acupuncture treatment is a complement to and not a substitute for Western medical care. Certain conditions may best be addressed in partnership with other health care providers.
8. I understand that my acupuncture practitioner follows universally prescribed precautions to guard against the spread of infection by using only sterilized, prepackaged, disposable needles. These needles will only be used on me and are inserted according to clean procedures based on nationally prescribed standards.

I have read and understand/agree to the information on this consent form.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Men's Acupuncture Patient Questionnaire**

Have you had acupuncture before?     Yes     No

What are the main reasons you're seeking acupuncture? \_\_\_\_\_

\_\_\_\_\_

How would you classify your condition:

- Minor                       Worsening                       Serious                       Severe/Life Altering

What other therapies have you tried for this condition? \_\_\_\_\_

\_\_\_\_\_

Please indicate if any of the following apply to you:

- Cancer                       Heart Condition                       HIV/AIDS                       Stroke/CVA  
 Diabetes                       Hemophiliac                       Lung Condition                       Takes Anticoagulants  
 Epilepsy                       Hepatitis                       Pacemaker                       Vegetarian/Vegan

Please list all surgeries and the date of the surgery:

Surgery

Date of Surgery

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any Significant Trauma? \_\_\_\_\_

Were *you* born via Natural Birth or C-Section? \_\_\_\_\_

Any Complications with Your Birth History: \_\_\_\_\_

Allergies: \_\_\_\_\_

List any medications, vitamins or food supplements taken in past two months.

Name of Medication or Product

Dosage

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you experienced any height or weight gains/losses over the past year?  Yes  No

If Yes, Please Explain: \_\_\_\_\_

**STRESS ASSESSMENT:**

What are your primary sources of stress?

- 1.
- 2.
- 3.

How much do you think they impact your life? \_\_\_\_\_

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments:
Spouse/Significant Other						
Family						
Diet						
Self						
Work						
Exercise						
Spirituality						

Occupation? \_\_\_\_\_ Do you like your work? Y N

How many hours do you work per week? \_\_\_\_\_ Number of play/relaxation hours? \_\_\_\_\_

What do you do in order to manage stress and take care of yourself? : \_\_\_\_\_

What do you believe is your greatest challenge? \_\_\_\_\_

**CURRENT MEDICAL STATUS:**

Date of last full physical? \_\_\_\_\_ If abnormal, explain: \_\_\_\_\_

If over age 50, have you had a colonoscopy?  Yes  No If Yes, Date of colonoscopy? \_\_\_\_\_

Any positive findings on colonoscopy?  Yes  No

If yes, explain: \_\_\_\_\_

Date of last eye exam? \_\_\_\_\_ If abnormal, explain: \_\_\_\_\_

How do you visit the dentist? \_\_\_\_\_

Personal history of skin cancer

Dental problems, gum inflammation or gingivitis? Please Explain: \_\_\_\_\_

**DIET & LIFESTYLE HABITS**

Currently on a restrictive diet

Diet is physician prescribed. If yes, for what condition? \_\_\_\_\_

I eat a healthy diet

Exercise (type, duration, frequency): \_\_\_\_\_

Estimated oz of water per day: \_\_\_\_\_

Caffeine Intake:  None  Coffee  Tea  Cola/Energy Drinks # of cups/cans per day \_\_\_\_\_

Do you consume alcohol?  Yes  No If yes, what type? \_\_\_\_\_

How many drinks per week? \_\_\_\_\_

Do you use tobacco?  Yes  No If yes, what type? \_\_\_\_\_

How many per day? \_\_\_\_\_ Number of years used: \_\_\_\_\_

Do you use recreational drugs?  Yes  No

Type of drug: \_\_\_\_\_ Frequency: \_\_\_\_\_

Please describe a typical day's diet...

Breakfast	Lunch	Dinner	Snacks (when?)

## OTHER SYMPTOMS AND SYSTEMS

Please indicate if you regularly experience any of the following:

### Head & Neck:

- |                                    |  |                                     |
|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraine              | <input type="checkbox"/> Headache   |
| <input type="checkbox"/> Fainting  | <input type="checkbox"/> Enlarged lymph glands | <input type="checkbox"/> Stiff neck |

Other: \_\_\_\_\_

### Eyes & Ears:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Burning/itching eyes | <input type="checkbox"/> Earache               | <input type="checkbox"/> Decreased hearing |
| <input type="checkbox"/> Dry eyes             | <input type="checkbox"/> Spots/floaters        | <input type="checkbox"/> Poor night vision |
| <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Chronic ear infection | <input type="checkbox"/> Vertigo           |
| <input type="checkbox"/> Blurred vision       | <input type="checkbox"/> Eye pain              | <input type="checkbox"/> Visual changes    |

Other: \_\_\_\_\_

### Respiratory/Nose:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Difficulty breathing    | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cough with phlegm | <input type="checkbox"/> Nosebleeds              | <input type="checkbox"/> Coughing up blood   |
| <input type="checkbox"/> Nasal congestion  | <input type="checkbox"/> Chronic sinus infection | <input type="checkbox"/> Hay fever/allergies |
| <input type="checkbox"/> Chronic Cough     | <input type="checkbox"/> Frequent Colds          | <input type="checkbox"/> Wheezing/Asthma     |

Other: \_\_\_\_\_

### Genital/Urinary:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bedwetting          | <input type="checkbox"/> Genital lesions/discharge | <input type="checkbox"/> Painful/burning urination |
| <input type="checkbox"/> Frequent urination  | <input type="checkbox"/> Pain/itching of genitalia | <input type="checkbox"/> Excessive/scant urination |
| <input type="checkbox"/> Nighttime urination | <input type="checkbox"/> Decreased libido          | <input type="checkbox"/> Increased libido          |
| <input type="checkbox"/> Blood in urine      | <input type="checkbox"/> Kidney Stone              | <input type="checkbox"/> Urgent urination          |

Other: \_\_\_\_\_

### Cardiovascular:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chest pain/tightness | <input type="checkbox"/> Swelling feet/ankles | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Heart palpitations   | <input type="checkbox"/> Varicose veins   |

Other: \_\_\_\_\_

### Mouth & Throat:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Bleeding gums             | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Dry mouth             | <input type="checkbox"/> Lump in throat            |  |
| <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Tongue/Mouth sores/ulcers |  |

Other: \_\_\_\_\_

### Muscles & Joints:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Body aches/stiffness | <input type="checkbox"/> Joint swelling       | <input type="checkbox"/> Joint pain               |
| <input type="checkbox"/> Joint discoloration  | <input type="checkbox"/> Generalized weakness | <input type="checkbox"/> Numbness/tingling        |
|   |   | <input type="checkbox"/> Heaviness" of body/limbs |

Other: \_\_\_\_\_

### Skin:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acne               | <input type="checkbox"/> Eczema/psoriasis | <input type="checkbox"/> Spontaneous sweat      |
| <input type="checkbox"/> Dry skin           | <input type="checkbox"/> Night sweats     | <input type="checkbox"/> Changes in moles/lumps |
| <input type="checkbox"/> Itchy skin         | <input type="checkbox"/> Bruise easily    |   |
| <input type="checkbox"/> Brittle/weak nails | <input type="checkbox"/> Hives/Rashes     |   |

Other: \_\_\_\_\_

**Gastrointestinal:**

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Acid reflux/heartburn    | <input type="checkbox"/> Loose/soft stool | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Blood in stool           | <input type="checkbox"/> Bad breath       | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Intestinal pain/cramping | <input type="checkbox"/> Gas              | <input type="checkbox"/> Bloating    |
| <input type="checkbox"/> Anal fissures            | <input type="checkbox"/> Mucous in stool  | <input type="checkbox"/> Hiccups     |
| <input type="checkbox"/> Constipation             | <input type="checkbox"/> Black stool      | <input type="checkbox"/> Vomiting    |

Other: \_\_\_\_\_

**Appetite/Thirst:**

- Temperature of drinks most commonly desired:  Very cold  Tepid  Very Hot
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Exceedingly hungry | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Hunger w/no desire to eat   |
| <input type="checkbox"/> No thirst          | <input type="checkbox"/> Poor appetite    | <input type="checkbox"/> Thirst w/no desire to drink |

Other: \_\_\_\_\_

**Sleep:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Difficulty waking up   | <input type="checkbox"/> Sound/restful             | <input type="checkbox"/> Trouble falling asleep |
| <input type="checkbox"/> Trouble staying asleep | <input type="checkbox"/> Vivid dreaming/nightmares | <input type="checkbox"/> Wake easily            |

# hours sleep/night: \_\_\_\_\_ Other: \_\_\_\_\_

**Emotions:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Angry/Frustrated | <input type="checkbox"/> Anxious               | <input type="checkbox"/> Depressed/sad |
| <input type="checkbox"/> Fearful          | <input type="checkbox"/> Forgetful/poor memory | <input type="checkbox"/> Impatient     |
| <input type="checkbox"/> Manic            | <input type="checkbox"/> Relaxed/calm          | <input type="checkbox"/> Stressed      |

Other: \_\_\_\_\_

**General:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Always feel cold | <input type="checkbox"/> Fever& Chills   | <input type="checkbox"/> Fatigue                           |
| <input type="checkbox"/> Cold hands/feet  | <input type="checkbox"/> Always feel hot | <input type="checkbox"/> Recent unexplained weight changes |

Other: \_\_\_\_\_

**Please select YES or NO for each question:**

**KIDNEY YIN DEFICIENCY**

	<b>Yes</b>	<b>No</b>
Do you have low back weakness/soreness/pain, or knee problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have ringing in your ears or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair prematurely gray?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark circles around or under your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
Would you describe yourself as one who is often afraid?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue lack coating? Does it appear shiny or peeled?	<input type="checkbox"/>	<input type="checkbox"/>

**KIDNEY YANG DEFICIENCY**

	<b>Yes</b>	<b>No</b>
Is your low back sore or weak?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cold feet; especially at night?	<input type="checkbox"/>	<input type="checkbox"/>
Are you typically colder than those around you?	<input type="checkbox"/>	<input type="checkbox"/>
Is your libido low?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often fearful?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up at night/early morning because you have to urinate?	<input type="checkbox"/>	<input type="checkbox"/>
Do you urinate frequently, and is the urine diluted and/or profuse?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have early morning loose, urgent stools?	<input type="checkbox"/>	<input type="checkbox"/>
Is your tongue pale, moist, and swollen?	<input type="checkbox"/>	<input type="checkbox"/>

**SPLEEN QI DEFICIENCY**

	<b>Yes</b>	<b>No</b>
Are you fatigued?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Is your energy level lower after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated after eating?	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have loose stools, abdominal pain, or digestive problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are your hands and feet cold?	<input type="checkbox"/>	<input type="checkbox"/>
Is your nose cold?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to feeling heavy or sluggish?	<input type="checkbox"/>	<input type="checkbox"/>
Are you feeling heaviness or grogginess in the head?	<input type="checkbox"/>	<input type="checkbox"/>
Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you have poor circulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking strength in your arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you lacking in exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to worry?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot with minimal exertion?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel dizzy/light-headed, or have altered vision if you stand up too fast?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often sick, or do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with hypothyroid or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids or polyps?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue look swollen with teeth marks on the sides?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pale, yellowish complexion?	<input type="checkbox"/>	<input type="checkbox"/>

**BLOOD DEFICIENCY**

	<b>Yes</b>	<b>No</b>
Do you have dry, flaky skin?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to getting chapped lips?	<input type="checkbox"/>	<input type="checkbox"/>
Are your fingernails or toenails brittle?	<input type="checkbox"/>	<input type="checkbox"/>
Are you losing the hair on your head (not patches, but all over)?	<input type="checkbox"/>	<input type="checkbox"/>
Is your hair brittle or dry?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diminished nighttime vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dizzy or light-headed around your period?	<input type="checkbox"/>	<input type="checkbox"/>
Are your lips, the inner side of your lower eyelids, or tongue pale in color?	<input type="checkbox"/>	<input type="checkbox"/>

<b>BLOOD STASIS</b>	<b>Yes</b>	<b>No</b>
Do you experience periodic numbness in your hands and feet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have varicose or spider veins?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have red hemangiomas (cherry-red spots) on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
Does your complexion appear dark and "sooty"?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>
Is your lower abdomen tender to palpation (resisting touch)?	<input type="checkbox"/>	<input type="checkbox"/>
Can you feel any abdominal lumps in your lower abdomen?	<input type="checkbox"/>	<input type="checkbox"/>
Does your tongue look dark?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots on your tongue?	<input type="checkbox"/>	<input type="checkbox"/>
Are the veins beneath your tongue twisty and tortuous?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark spots in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a vascular abnormality or blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<b>LIVER QI STAGNATION</b>	<b>Yes</b>	<b>No</b>
Are you prone to emotional depression?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to anger and/or rage?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with elevated prolactin levels?	<input type="checkbox"/>	<input type="checkbox"/>
Are your pupils dilated and large?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty falling asleep at night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience heartburn or wake up with a bitter taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEART DEFICIENCY</b>	<b>Yes</b>	<b>No</b>
Do you wake early and have trouble getting back to sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heart palpitations, especially when anxious?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>
Do you seem low in spirit or lacking in vitality?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to agitation or extreme restlessness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you fidget?	<input type="checkbox"/>	<input type="checkbox"/>
Is the tip of your tongue red?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a crack in the center of your tongue that extends to the tip?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat excessively, especially on your chest?	<input type="checkbox"/>	<input type="checkbox"/>
<b>EXCESS HEAT</b>	<b>Yes</b>	<b>No</b>
Is your pulse rate rapid?	<input type="checkbox"/>	<input type="checkbox"/>
Are your mouth and throat usually dry?	<input type="checkbox"/>	<input type="checkbox"/>
Are you thirsty for cold drinks most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel warmer than those around you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up sweating or have hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you break out with red acne (especially pre-menstrual)?	<input type="checkbox"/>	<input type="checkbox"/>
<b>DAMPNESS</b>	<b>Yes</b>	<b>No</b>
Do you feel tired and sluggish after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cystic or pustular acne?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have urgent, bright, or foul-smelling stools?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to yeast infections ?	<input type="checkbox"/>	<input type="checkbox"/>
Do your joints ache, especially with movement?	<input type="checkbox"/>	<input type="checkbox"/>
Are you overweight?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a wet slimy tongue?	<input type="checkbox"/>	<input type="checkbox"/>