



Women'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. 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 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: _____

Women'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: _____

Are you pregnant or is there any chance that you are pregnant? Yes No

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: _____

Have you had a mammogram? Yes No If Yes, Date of last mammogram? _____

How often do you get a mammogram performed? _____

Any positive findings on your mammogram(s)? Yes No

If yes, explain: _____

Have you had a thermogram? Yes No If Yes, Date of last thermogram? _____

How often do you get a thermogram performed? _____

Any positive findings on your thermogram(s)? Yes No

If yes, explain: _____

Date of last eye exam? _____ If abnormal, explain: _____

How often 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:

- Dizziness
- Fainting
- Migraine
- Enlarged lymph glands
- Headache
- Stiff neck

Other: _____

Eyes & Ears:

- Burning/itching eyes
- Dry eyes
- Ringing in ears
- Blurred vision
- Earache
- Spots/floaters
- Chronic ear infection
- Eye pain
- Decreased hearing
- Poor night vision
- Vertigo
- Visual changes

Other: _____

Respiratory/Nose:

- Bronchitis
- Cough with phlegm
- Nasal congestion
- Chronic Cough
- Difficulty breathing
- Nosebleeds
- Chronic sinus infection
- Frequent Colds
- Shortness of breath
- Coughing up blood
- Hay fever/allergies
- Wheezing/Asthma

Other: _____

Genital/Urinary:

- Bedwetting
- Frequent urination
- Nighttime urination
- Blood in urine
- Genital lesions/discharge
- Pain/itching of genitalia
- Decreased libido
- Kidney Stone
- Painful/burning urination
- Excessive/scant urination
- Increased libido
- Urgent urination

Other: _____

Cardiovascular:

- Chest pain/tightness
- Irregular heart beat
- Swelling feet/ankles
- Heart palpitations
- Poor circulation
- Varicose veins

Other: _____

Mouth & Throat:

- Bitter taste in mouth
- Dry mouth
- Recurrent sore throat
- Bleeding gums
- Lump in throat
- Tongue/Mouth sores/ulcers
- Difficulty swallowing

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

Yes

No

- Do you have low back weakness/soreness/pain, or knee problems? Yes No
- Do you have ringing in your ears or dizziness? Yes No
- Is your hair prematurely gray? Yes No
- Do you have vaginal dryness? Yes No
- Is your mid-cycle fertile cervical mucus scanty or missing? Yes No
- Do you have dark circles around or under your eyes? Yes No
- Do you have night sweats? Yes No
- Are you prone to hot flashes? Yes No
- Would you describe yourself as one who is often afraid? Yes No
- Does your tongue lack coating? Does it appear shiny or peeled? Yes No

KIDNEY YANG DEFICIENCY

Yes

No

- Do you have premenstrual low back pain? Yes No
- Is your low back sore or weak? Yes No
- Do you have cold feet; especially at night? Yes No
- Are you typically colder than those around you? Yes No
- Is your libido low? Yes No
- Are you often fearful? Yes No
- Do you wake up at night/early morning because you have to urinate? Yes No
- Do you urinate frequently, and is the urine diluted and/or profuse? Yes No
- Do you have early morning loose, urgent stools? Yes No
- Do you have excess vaginal discharge? Yes No
- Do you feel cold cramps during periods that respond to a heating pad? Yes No
- Is your tongue pale, moist, and swollen? Yes No

SPLEEN QI DEFICIENCY

Yes

No

- Are you fatigued? Yes No
- Do you have a poor appetite? Yes No
- Is your energy level lower after a meal? Yes No
- Do you feel bloated after eating? Yes No
- Do you crave sweets? Yes No
- Do you have loose stools, abdominal pain, or digestive problems? Yes No
- Are your hands and feet cold? Yes No
- Is your nose cold? Yes No
- Are you prone to feeling heavy or sluggish? Yes No
- Are you feeling heaviness or grogginess in the head? Yes No
- Do you bruise easily? Yes No
- Do you think you have poor circulation? Yes No
- Do you have varicose veins? Yes No
- Are you lacking strength in your arms and legs? Yes No
- Are you lacking in exercise? Yes No
- Are you prone to worry? Yes No
- Have you been diagnosed with low blood pressure? Yes No
- Do you sweat a lot with minimal exertion? Yes No
- Do you feel dizzy/light-headed, or have altered vision if you stand up too fast? Yes No
- Is your menstruation thin, watery, profuse, or pinkish in color? Yes No
- Are you more tired around ovulation and menstruation? Yes No
- Do you ever spot a few days or more before your period comes? Yes No
- Have you ever been diagnosed with uterine prolapse? Yes No
- Are cramps accompanied by a bearing-down sensation in your uterus? Yes No
- Are you often sick, or do you have allergies? Yes No
- Have you been diagnosed with hypothyroid or anemia? Yes No
- Do you have hemorrhoids or polyps? Yes No
- Does your tongue look swollen with teeth marks on the sides? Yes No
- Do you have a pale, yellowish complexion? Yes No

BLOOD DEFICIENCY	Yes	No
Are your menses scant and/or late?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

BLOOD STASIS	Yes	No
Is your menstrual flow ever brown or black in color?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel mid-cycle pain around your ovaries?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have painful, unmovable breast lumps?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Does your menstrual blood contain clots?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with endometriosis or uterine fibroids?	<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"/>
Do you have piercing or stabbing menstrual cramps?	<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"/>

LIVER QI STAGNATION	Yes	No
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"/>
Do you become irritable when premenstrual?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bloated and irritable around ovulation?	<input type="checkbox"/>	<input type="checkbox"/>
Does it feel as if your ovulation lasts longer than it should?	<input type="checkbox"/>	<input type="checkbox"/>
Are your breasts sensitive/sore at ovulation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience nipple pain or discharge from your nipples?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with elevated prolactin levels?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become bloated prior to menstruation?	<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"/>
Are your menses painful?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your menstrual cramps in the external genital area?	<input type="checkbox"/>	<input type="checkbox"/>
Is the menstrual blood thick and dark, or purplish in color?	<input type="checkbox"/>	<input type="checkbox"/>

HEART DEFICIENCY	Yes	No
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"/>

EXCESS HEAT

	Yes	No
Is your pulse rate rapid?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth and/or 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"/>
Do you have a short menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal irritation or rashes?	<input type="checkbox"/>	<input type="checkbox"/>

DAMPNESS

	Yes	No
Do you feel tired and sluggish after a meal?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have fibrocystic breasts?	<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"/>
Does your menstrual blood contain stringy tissue or mucus?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to yeast infections and vaginal itching?	<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"/>

DAMP HEAT

	Yes	No
Do you have foul-smelling, yellow, or greenish vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal or rectal itching during luteal or premenstrual phase?	<input type="checkbox"/>	<input type="checkbox"/>

COLD UTERUS

	Yes	No
Do you fit the Kidney Yang deficiency category?	<input type="checkbox"/>	<input type="checkbox"/>
Do you fall into the Blood Stasis pattern?	<input type="checkbox"/>	<input type="checkbox"/>
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	<input type="checkbox"/>	<input type="checkbox"/>