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: ___________________________________

Take 2 Healthcare
5777 Far Hills Ave, Dayton, Ohio 45429
Phone: (937) 433-3241 Fax (937) 496-5468 Email: mail@take2healthcare.com

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: ____

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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?)

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OTHER SYMPTOMS AND SYSTEMS
Please indicate if you regularly experience any of the following:

Head & Neck:

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

Other:____

Eyes & Ears:

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

Other:____

Respiratory/Nose:

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

Other:____

Genital/Urinary:

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

Other:____

Cardiovascular:

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

Other:____

Mouth & Throat:

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

Other:____

Muscles & Joints:

- ☐ Body aches/stiffness
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Joint discoloration
- ☐ Generalized weakness
- ☐ Numbness/tingling
- ☐ Heaviness" of body/limbs

Other:____

Skin:

- ☐ Acne
- ☐ Eczema/psoriasis
- ☐ Spontaneous sweat
- ☐ Dry skin
- ☐ Night sweats
- ☐ Changes in moles/lumps
- ☐ Itchy skin
- ☐ Bruise easily
- ☐ Brittle/weak nails
- ☐ Hives/Rashes

Other:____

Gastrointestinal:

- ☐ Acid reflux/heartburn
- ☐ Loose/soft stool
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Bad breath
- ☐ Nausea
- ☐ Intestinal pain/cramping
- ☐ Gas
- ☐ Bloating
- ☐ Anal fissures
- ☐ Mucous in stool
- ☐ Hiccups
- ☐ Constipation
- ☐ Black stool
- ☐ Vomiting

Other:____

Appetite/Thirst:

Temperature of drinks most commonly desired: ☐ Very cold ☐ Tepid ☐ Very Hot

- ☐ Exceedingly hungry
- ☐ Excessive thirst
- ☐ Hunger w/no desire to eat
- ☐ No thirst
- ☐ Poor appetite
- ☐ Thirst w/no desire to drink

Other:____

Sleep:

- ☐ Difficulty waking up
- ☐ Sound/restful
- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Vivid dreaming/nightmares
- ☐ Wake easily

hours sleep/night: _________ Other:____

Emotions:

- ☐ Angry/Frustrated
- ☐ Anxious
- ☐ Depressed/sad
- ☐ Fearful
- ☐ Forgetful/poor memory
- ☐ Impatient
- ☐ Manic
- ☐ Relaxed/calm
- ☐ Stressed

Other:____

General:

- ☐ Always feel cold
- ☐ Fever& Chills
- ☐ Fatigue
- ☐ Cold hands/feet
- ☐ Always feel hot
- ☐ 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?	◻	◻
Do you have ringing in your ears or dizziness?	◻	◻
Is your hair prematurely gray?	◻	◻
Do you have dark circles around or under your eyes?	◻	◻
Do you have night sweats?	◻	◻
Are you prone to hot flashes?	◻	◻
Would you describe yourself as one who is often afraid?	◻	◻
Does your tongue lack coating? Does it appear shiny or peeled?	◻	◻

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

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

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

BLOOD STASIS	Yes	No
Do you experience periodic numbness in your hands and feet?	□	□
Do you have varicose or spider veins?	□	□
Do you have red hemangiomas (cherry-red spots) on your skin?	□	□
Does your complexion appear dark and “sooty”?	□	□
Do you have chronic hemorrhoids?	□	□
Is your lower abdomen tender to palpation (resisting touch)?	□	□
Can you feel any abdominal lumps in your lower abdomen?	□	□
Does your tongue look dark?	□	□
Do you have dark spots on your tongue?	□	□
Are the veins beneath your tongue twisty and tortuous?	□	□
Do you have dark spots in your eyes?	□	□
Do you have a vascular abnormality or blood clotting disorder?	□	□

LIVER QI STAGNATION	Yes	No
Are you prone to emotional depression?	□	□
Are you prone to anger and/or rage?	□	□
Have you been diagnosed with elevated prolactin levels?	□	□
Are your pupils dilated and large?	□	□
Do you have difficulty falling asleep at night?	□	□
Do you experience heartburn or wake up with a bitter taste in your mouth?	□	□

HEART DEFICIENCY	Yes	No
Do you wake early and have trouble getting back to sleep?	□	□
Do you have heart palpitations, especially when anxious?	□	□
Do you have nightmares?	□	□
Do you seem low in spirit or lacking in vitality?	□	□
Are you prone to agitation or extreme restlessness?	□	□
Do you fidget?	□	□
Is the tip of your tongue red?	□	□
Is there a crack in the center of your tongue that extends to the tip?	□	□
Do you sweat excessively, especially on your chest?	□	□

EXCESS HEAT	Yes	No
Is your pulse rate rapid?	□	□
Are your mouth and throat usually dry?	□	□
Are you thirsty for cold drinks most of the time?	□	□
Do you often feel warmer than those around you?	□	□
Do you wake up sweating or have hot flashes?	□	□
Do you break out with red acne (especially pre-menstrual)?	□	□

DAMPNESS	Yes	No
Do you feel tired and sluggish after a meal?	□	□
Do you have cystic or pustular acne?	□	□
Do you have urgent, bright, or foul-smelling stools?	□	□
Are you prone to yeast infections ?	□	□
Do your joints ache, especially with movement?	□	□
Are you overweight?	□	□
Do you have a wet slimy tongue?	□	□