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 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: _____

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: _____

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

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? : _____

_____

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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? _____

☐ Dental problems, gum inflammation or gingivitis?

☐ Please Explain:_____

☐ Personal history of skin cancer

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 ☐ 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 ☐ Blurred vision ☐ Chronic ear infection ☐ Eye pain ☐ Vertigo ☐ 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 vaginal dryness?	□	□
Is your mid-cycle fertile cervical mucus scanty or missing?	□	□
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**
Do you have premenstrual low back pain?	□	□
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?	□	□
Do you have excess vaginal discharge?	□	□
Do you feel cold cramps during periods that respond to a heating pad?	□	□
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?	□	□
Is your menstruation thin, watery, profuse, or pinkish in color?	□	□

Are you more tired around ovulation and menstruation?	□	□
Do you ever spot a few days or more before your period comes?	□	□
Have you ever been diagnosed with uterine prolapse?	□	□
Are cramps accompanied by a bearing-down sensation in your uterus?	□	□
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**
Are your menses scant and/or late?	□	□
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**
Is your menstrual flow ever brown or black in color?	□	□
Do you feel mid-cycle pain around your ovaries?	□	□
Do you have painful, unmovable breast lumps?	□	□
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?	□	□
Does your menstrual blood contain clots?	□	□
Have you been diagnosed with endometriosis or uterine fibroids?	□	□
Is your lower abdomen tender to palpation (resisting touch)?	□	□
Can you feel any abdominal lumps in your lower abdomen?	□	□
Do you have piercing or stabbing menstrual cramps?	□	□
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?	□	□
Do you become irritable premenstrually?	□	□
Do you feel bloated and irritable around ovulation?	□	□
Does it feel as if your ovulation lasts longer than it should?	□	□
Are your breasts sensitive/sore at ovulation?	□	□
Do you experience nipple pain or discharge from your nipples?	□	□
Have you been diagnosed with elevated prolactin levels?	□	□
Do you become bloated prior to menstruation?	□	□
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?	□	□
Are your menses painful?	□	□
Do you feel your menstrual cramps in the external genital area?	□	□
Is the menstrual blood thick and dark, or purplish in color?	□	□

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)?	□	□
Do you have a short menstrual cycle?	□	□
Do you have vaginal irritation or rashes?	□	□

DAMPNESS	**Yes**	**No**
Do you feel tired and sluggish after a meal?	□	□
Do you have fibrocystic breasts?	□	□
Do you have cystic or pustular acne?	□	□
Do you have urgent, bright, or foul-smelling stools?	□	□
Does your menstrual blood contain stringy tissue or mucus?	□	□
Are you prone to yeast infections and vaginal itching?	□	□
Do your joints ache, especially with movement?	□	□
Are you overweight?	□	□

Do you have a wet slimy tongue?	□	□

DAMP HEAT	**Yes**	**No**
Do you have foul-smelling, yellow, or greenish vaginal discharge?	□	□
Do you have vaginal or rectal itching during luteal or premenstrual phase?	□	□

COLD UTERUS	**Yes**	**No**
Do you fit the Kidney Yang deficiency category?	□	□
Do you fall into the Blood Stasis pattern?	□	□
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	□	□