nuyu acupuncture

Confidential Health Intake Form

Thank you for taking the time to complete the following information, which better helps us to assess your health needs. All information is confidential. We are happy to answer any questions that you may have.

Client's Name: _____ Marital Status: _____ Date:_____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F/T Height: _____ Weight: _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email_____ How did you hear about us? _____

Occupation: _____ Hobbies: _____ Employer: _____

Emergency Contact: _____ Phone Number: _____

Have you ever had acupuncture before? Y / N What was the result? _____

Please list your main health concerns in order of importance?

1._____

2._____ 4. _____

3._____ 5. _____

Which of these health concerns has been diagnosed by a Medical Doctor (MD) _____

Significant Family Health History: _____

_____

_____

Is there any chance you are pregnant? Y/ N

Describe your menstruation cycle. *(Length of flow and cycle, color of blood, etc.)*_____

_____

Do you have any infectious diseases? Y/ N (*if yes which ones)* _____

_____

Please (circle) any symptom you experience now and underline any that you have experienced in the past

Mental- Emotional: mood swings nervousness/anxiety obsessive thinking Depression poor memory Insomnia sadness worry anger mental fogginess

Energy and Immunity: fatigue slow wound healing chronic infections Chronic Fatigue Syndrome night sweats lack of sweating unusual sweating (palms, soles, elsewhere) frequently catch colds

Respiratory: difficulty breathing Emphysema persistent cough Pleurisy Pneumonia Asthma Tuberculosis shortness of breath other respiratory problems:_____

Head, Eye, Ear, Nose, and Throat: impaired vision eye pain/strain glaucoma glasses/contacts tearing/dryness impaired hearing ear ringing earaches ear infection headaches sinus problems nose bleeds frequent sore throats teeth grinding Hay Fever TMD/jaw problems Strep Throat sore throat itchy throat sensation of something stuck in your throat excessive thirst

List allergies:_____

Cardiovascular: Heart Disease chest pain swelling of ankles High Blood Pressure/ Low BP palpitations/fluttering atrial fibrillation stroke heart murmurs Rheumatic Fever Varicose Veins dizziness

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Gastrointestinal: Ulcers changes in appetite nausea/vomiting GI pain passing gas belching
acid reflux Gall Bladder Disease Liver Disease Hepatitis Hemorrhoids constipation diarrhea
Irritable Bowl Syndrome blood in stools polyps Pancreatitis poor appetite sweet cravings

Genito-Urinary Tract: Kidney Disease painful urination frequent UTI frequent urination
Kidney Stones Incontinence blood in urine Urination at Night difficult urination

Female Reproductive/Breasts: irregular cycles breast lumps/tenderness nipple discharge vaginal discharge
premenstrual problems bleeding between cycles heavy or light flow menopausal symptoms
difficulty conceiving painful periods low libido emotional reactions Hysterectomy
Endometriosis pregnancies Births how many___?

Male Reproductive sexual difficulties prostrate problems testicular pain/swelling penile discharge
vasectomy infertility or abnormal testing

Musculoskeletal: neck/shoulder pain muscle spasms/cramps arm pain upper back pain
mid back pain low back pain leg pain joint pain (if so, where?):_____

Neurologic: vertigo/dizziness paralysis numbness/tingling loss of balance seizures/epilepsy

Endocrine: Hypothyroid Hypoglycemia Hyperthyroid Diabetes feeling Hot or Cold
Obesity Other hormone imbalances_____

Autoimmune and Inflammatory Conditions: Hashimoto's Disease Rheumatic Arthritis Fibromyalgia
swollen glands Chronic Fatigue Plantar Fasciitis Staphylococci infections Uveitis Iritis Crohn's Disease

Other: Anemia Cancer rashes Eczema/Hives cold hands/feet Psoriasis
Fungal infections Shingles bruise easily other_____

Lifestyle: regular exercise tobacco caffeine occupational hazards spiritual practice/community
alcohol recreational drugs stress how often do you eat sugar?_____
How often do you drink water?_____ How much per day? _____
What do you eat? How many fruits and Vegetables do you eat on a daily basis? _____
Breakfast:_____ Lunch:_____
Dinner:_____ Snacks:_____
Is there anything else we should know? _____
_____

Short Term Goals (STG):

☐Decrease Inflammation	☐Increase Strength	☐Increase Stability
☐Decrease Pain	☐Increase Mobility	☐Increase General Fitness
☐Increase Range of Motion	☐Improve Gait	☐Restore Ligament Function
☐Decrease Compensatory Patterns	☐Increase Activities of Daily Living	☐Improve/Restore Posture
☐ Reduce/Eliminate Pain Medications		

Long Term Goals (LTG):
1.

2.

3.
Signature:_____ Date:_____/_____/_____

Initial Here: _____ to receive our newsletter, special offers, a FREE allergy treatment, and Referral Rewards!

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Client Information:

Last Name:_____ First Name:_____

Name: _____ DOB: _____

DRUGS and SUPPLEMENTS

Date	SUBSTANCES	Initials

Date	ALLERGIES and WARNINGS	Initials

Date	SURGERIES and MAJOR LIFE EVENTS	Initials

1. What prompted you to come see me?

2. What three specific expectations do you have from this visit?
   a.
   b.
   c.

3. What expectations do you have of me personally?

4. Describe your current state of health.

5. What behaviors of yours support health?

6. What behaviors of yours undermine health?

7. What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle?

HOW INTERESTED ARE IN ADDRESSING THE FOLLOWING AREAS **Range from 1 - 10**

Career	Family & Friends	Significant Others	Money
Health	Fun & Recreation	Physical Environment	Personal Growth

PRIMARY FOCUS

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Informed Consent to Treat

Client Name: _____

CONSENT TO TREATMENT: This agreement made this _____ day of _____, 20_____, by and between **Rik Ehmann,** (Acupuncturist) and _____ (Client).
Consent to treatment for myself, or for my family member who is a minor or dependent adult.
The Acupuncturist shall provide treatment as it pertains to the client(s) needs.
All therapy will be within the scope of professional practice per the State of Kentucky Board of License for Acupuncture.
I understand that the Acupuncturist has a Master's of Acupuncture and Oriental Medicine.

DISCLOSURE STATEMENT: Rik Ehmann LAc is established to provide health care services to the public in the field of Asian Medical Therapies: including the insertion of acupuncture needles, with or without electric stimulation or heat, and may include acupressure, cupping, moxibustion or the application of dermal friction. An Acupuncturist utilizes approaches that are the best fit for each client(s) needs and goals.
I understand that participating in sessions with an Acupuncturist can be very helpful and can result in improved health and a better, fuller life.

POSSIBLE SIDE EFFECTS OF ACUPUNCTURE:
Sometimes, the natural course of the body's process is to temporarily appear to be getting worse through signs of bruising, or increased irritation or pain, while the healing process progresses.

Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist and that patients seeking adjunctive cancer support are under the care of an oncologist. 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) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, infrared therapy, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.
Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. I understand that I must inform, and continue to fully inform, this office of any medications, and/or

supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit. By voluntarily signing below, I confirm that I have read, or have had read to me, the above 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 agree with the current or future recommendations for care. 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 Name _____ Responsible Party _____

Patient (or Responsible Party's) signature

_____ Date: _____

Office signature

_____ Date: _____