

Water of Life NaturoPathic Healthcare

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Acupuncture/ Oriental Medicine Intake Form

Please complete all the fields below as accurately as possible, even if you feel certain questions don't pertain to your current condition. All information is kept confidential. Thank You.

Name: _____ Date: _____

Address: _____

City _____ State _____ Zip _____

Email: _____

Phone: (C) _____ (H) _____ (W) _____

Height: _____ Weight: _____ Sex: _____

Date of Birth: _____ Age: _____

Employer: _____

Occupation: _____ Single/Married/Divorced/Widowed/Other
(circle)

Primary Physician: _____

Phone Number: _____

Referred by: _____

In Emergency, Notify: _____

Relationship: _____ Phone: _____

Main problem/s you would like help with:

- 1.
- 2.
- 3.

When did the problem/s begin (be specific):

To what extent does the problem/s interfere with your daily activity (work, exercise, sleep, sex, etc.)?

Have you been given a diagnosis for the problem/s? _____ If so, what? _____

What kind of treatments have you tried? _____

Other concurrent therapies: _____

Medications

What medications are you currently taking? Please list name, reason, dosage.

Habits

Do you have a regular exercise program? _____ Please describe. _____

Please indicate usage per day or per week:

Water _____ glasses per day

Coffee _____ cups per day/week (circle)

Tea _____ cups per day/week (circle)

Alcohol _____ day/week Type liquor/beer/wine

Soft Drinks _____ day/week

Cigarettes _____ day/week

Sweets _____ day/week

Please describe your average daily diet: Be specific.

Morning:

Snack:

Lunch:

Snack:

Dinner:

Supplements/Herbs/Vitamins/Minerals: (Please list brand, product name, & reason for taking)

Please list your health goals or concerns:

- 1.
- 2.
- 3.

Muscles/ Bones/ Joints

Do you have pain or tightness? No / Yes. If Yes, please indicate the location on the chart below.

The pain is (circle all that apply):

Sharp Dull Aching Numb Superficial Pain

Burning Tingling Shooting Deep Pain Pain worse in am/pm

Pain worse/better with heat Pain worse/better with cold Pain worse/better with pressure

I have (circle all that apply):

Swollen joints Arthritis/joint pain Tendonitis Muscle cramping

Muscle pain Repetitive Strain Injury Bone Pain Fractured Bone(s)

Where? _____

Please explain any injuries in the space provided:

Date of onset:

Location:

Duration of pain:

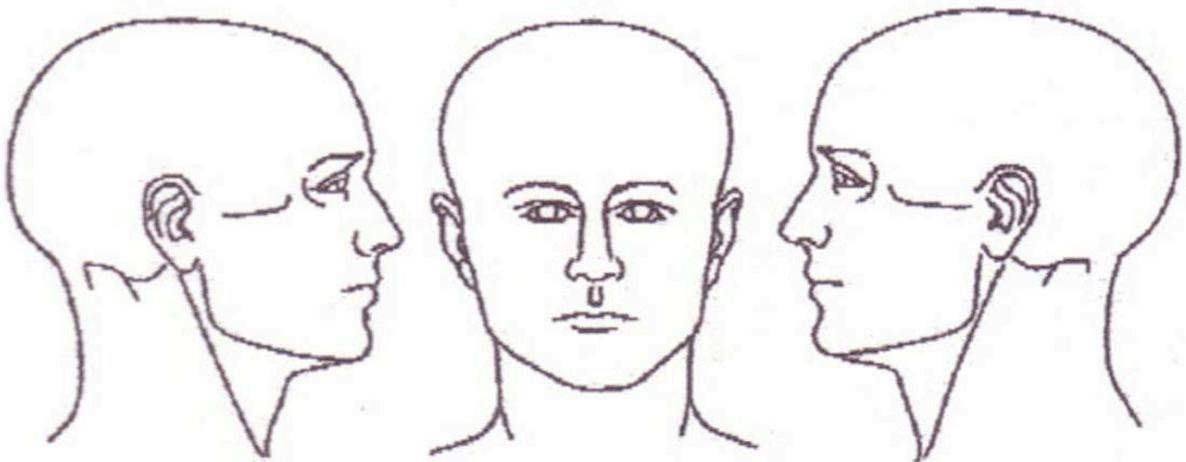
What makes the pain worse:

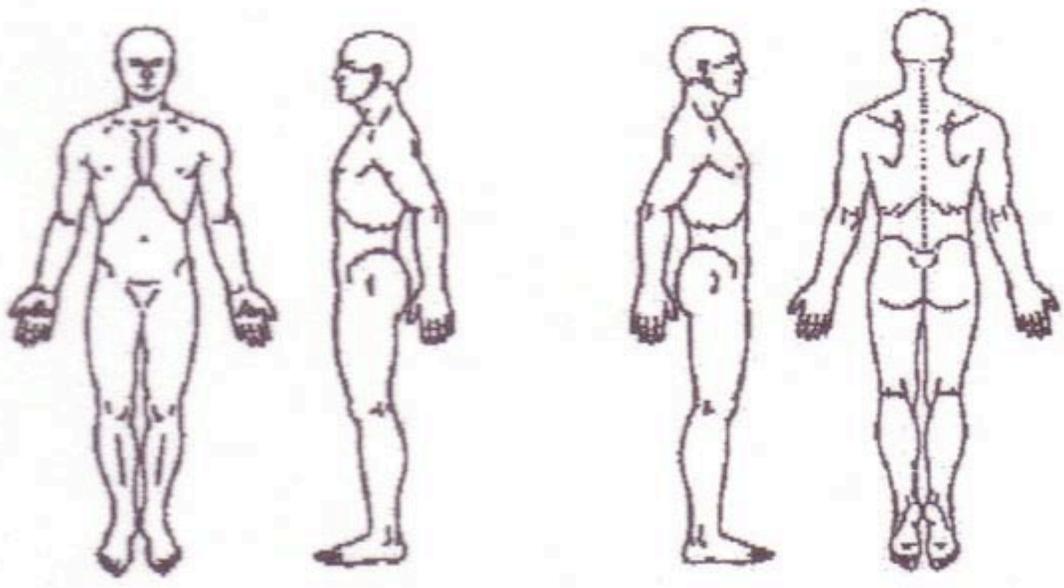
What makes the pain better (circle all the apply): Heat Cold Massage Movement Rest

Treatments: (ex. Ibuprofen, chiropractic)

What number best describes your pain now? *No Pain* 1 2 3 4 5 6 7 8 9 10 *Worst Pain*

Please indicate areas of pain or distress:





Medical History (Check all that apply):

- AIDS/HIV Alcoholism/Substance Abuse Thyroid Disease
- Allergies Hepatitis A / B / C Asthma
- Cancer Herpes Epilepsy
- Emphysema Lyme Disease Endocrine Disorder
- Diabetes Multiple Sclerosis Gout
- Heart Disease Pacemaker High Blood Pressure
- Seizures Polio Surgeries (please list)
- Tuberculosis Varicose Veins

Energy:

How is your energy? Please circle. *Low* 1 2 3 4 5 6 7 8 9 10 *High*

What time of day is your energy:

Highest: 6am-12pm/1pm-5pm/6pm-12am & **Lowest:** 6am-12pm/1pm-5pm/6pm-12am

Do you fatigue easily? Yes/ No

Emotions & Sleep:

How do you feel emotionally?

Do you have (circle all that apply):

- Panic attacks Depression Anxiety Bad temper
- Nervousness Fear attacks Poor memory Difficult concentration

How do you handle stress?

How do you relax?

How do you feel about your work?

How long do you normally sleep? _____ hours per night

I have difficulties with (circle all that apply):

- Falling asleep Staying asleep Dream-disturbed sleep
- Waking up at about _____am/pm and not being able to fall asleep again

Gastrointestinal:

I have (check all that apply):

- Belching Nausea Vomiting Ulcers Bloating
- Heartburn Acid Reflux Severe stomach pain Other:_____

Bowel movements: How often? _____time(s)/day or _____days/week

Use Laxatives? _____

I have (circle all that apply):

Irregular Bowel Movements Constipation Diarrhea Undigested food in stool

Burning sensation Hemorrhoids Itchiness Painful bowel movements

Loose stool Hard stool Blood in stool Gas

Urination:

Urination: How often? _____(times per day) Color: Pale yellow / Dark yellow / Orange /

Other _____

I have or had (circle all that apply):

Trouble starting stream Frequent urination Incontinence Dribbling when

sneezing Burning Pain Blood in urine Kidney stones Urinary tract infections

Other _____

Women Only:

Are you pregnant: Y / N Are you trying to get pregnant: Y / N

Age of first menses: _____ Pre-Menopausal: Y / N Menopausal: Y / N

Post-Menopausal: Y / N

Number of days between cycles: _____

Number of flow days: _____ Typical Color: dark red/ bright red/ pale red

I have or had (check all that apply):

Irregular menstruation Heavy flow Light flow No flow Clots

Vaginal itching/burning Spotting between periods Discomfort/pain before period

Irritability Breast Tenderness Cravings Cramps

Vaginal discharge? No / Yes Color_____

Number of pregnancies _____ Number of Children:_____

Men:

I have (circle all that apply):

Prostatitis Impotence Penis blood/mucous/discharge Reproductive problems

Other:_____

Eyes, Ears, Nose, Throat, & Head:

Do you smoke? No / Yes _____ per day, for _____ years

I have (check all that apply):

Frequent colds Chronic runny nose Frequent sore throat Chronic cough

Coughing blood Cough up mucous Pain inhaling Clogged/popping in ears

Nose bleeds Painful/red eyes Poor vision See spots/floaters Dizziness Bleeding gums Dry mouth Ear pain Ringing in ears

Shortness of breath on exertion/ or at rest Frequent headaches/migraines

Cardiovascular:

I have (circle all that apply):

Chest pain Palpitation Varicose veins Phlebitis Cold hands and feet

Irregular heart beat Poor circulation Hypertension High Cholesterol

Other:_____

Skin & Hair:

I have or often have (circle all that apply):

Dry skin Skin rashes Itching Acne Eczema Hives

Hair loss Premature graying Age spots

Other:_____

Are there any other health issues you want to discuss?

Informed Consent to Oriental Medical Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Dr. Vanessa Edwards, ND L. Ac.:

- Acupuncture and other Oriental Medical procedures including diagnostic techniques such as questioning, pulse evaluation, tongue evaluation, abdominal evaluation, observation, range of motion, muscle or orthopedic testing
- Manual or physical therapy including cupping, direct moxabustion, Tuina, electrical stimulation, infrared heat therapy
- The prescription of herbal therapy, dietary supplements, dietary recommendations
- Exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with Dr. Vanessa Edwards the nature and purpose of Acupuncture and Oriental Medicine. Although I am aware that Acupuncture and the other Oriental Medicine procedures have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are highly unlikely to occur, they are possible. I understand that these risks include, but are not limited to:

bleeding, bruising, burns, pain or other strong sensation at the location of needle insertion or radiating from that location, nerve pain, aggravation of current symptoms (healing crisis), appearance of new symptoms, or general aches and pains. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist's judgment during the course of my treatment.

I have read (or had read to me) this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s).

Patient's name (please print) Patient's signature

Date signed Witness

Print Name of Patient's Representative (if applicable) Relationship of Patient's Representative

Signature of Patient's Representative (if applicable)