Acupuncture for Harmony

The following information will be used by Sheridan Loudon, Acupuncture Physician, as part of your confidential record. No information contained herein will be released to third parties without your expressed consent. Please let me know if you have any concerns about the privacy of your records. Use the backs of pages if necessary.

Full Name _____ Date _____

Name you prefer to be called _____ Birth date _____

Address_____

City/State/ Zip _____

Home Ph _____Work Ph _____ Cell Ph _____

Email:_____ Occupation _____

Married ____ Single ____ Divorced _____ Widowed ____

Live alone ____ Live with _____

Emergency Contact Name and Phone _____

Referred by or how you learned about me _____

Primary Physician _____ Phone_____

Date of last complete physical exam _____

Other healthcare providers you see on a regular basis and what you see them for

_____ Reason _____

Reason for your visit today _____

How long have you had this condition? _____ Is it getting worse? ☐ Yes ☐ No

Does it bother your ☐ Sleep ☐ Work ☐ Other? What? _____

What seemed to be the initial cause? _____

What seems to make it better? _____ What seems to make it worse? _____

What was going on in your life when this started? _____

Please describe current complaints:_____

_____

_____

_____

_____

_____

Have you had acupuncture before? ☐ Yes ☐ No Chinese herbal medicine? ☐ Yes ☐ No

If yes, what did you have them for? _____

Please list any concerns you have about acupuncture treatment _____

_____

Medications you are currently taking and what they are meant to help

_____ _____ _____
_____ _____ _____
_____ _____ _____

Over-the-counter drugs, vitamins, herbs or supplements you are currently taking

_____ _____ _____
_____ _____ _____
_____ _____ _____

Your Diet

Appetite ☐ Low ☐ Avg ☐ High

☐ Coffee # ____
☐ Soft Drinks # ___

☐ Artificial Sweetener Daily Servings ___

☐ Sugar
☐ Salty Food

Thirst for water # glasses per day____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Your Lifestyle

☐ Alcohol _____ oz per week
☐ Smoking _____ cigs per day
☐ Marijuana # of uses per wk _____

☐ Drugs Frequency _____
☐ Stress
☐ Occupational Hazards

Height _____

How do you nurture your spirit?
_____
_____

Weight _____

☐ Regular Exercise

Type_____

Type_____

Exercise makes me: ☐ tired ☐ energized ☐ neither

Frequency/Duration _____

Frequency/Duration _____

Indigestion: ☐ gas ☐ bloating ☐ reflux ☐ constipation ☐ diarrhea ☐ other _____

Environmental Stressors: ☐ hot ☐ cold ☐ humid ☐ dry ☐ windy ☐ pressure changes

Chronic Infections: ☐ Candida ☐ Herpes ☐ EBV ☐ HPV ☐ HCV ☐ HIV ☐ Other_____

Allergies: ☐ dust ☐ pollen ☐ mold ☐ cats/dogs ☐ wheat ☐ dairy ☐ peanuts ☐ soy

☐ medications (specify): _____

Women: ☐ PMS ☐ irregular cycle ☐ peri-menopausal ☐ menopausal ☐ hot flashes

☐ infertility ☐ abnormal pap ☐ Other_____

Number of pregnancies: ___ miscarriages ___ abortions: ___ living children _____

Men: ☐ prostate problems ☐ urinary disorders ☐ erectile dysfunction ☐ infertility

☐ Other_____

Self Assessment Health Profile

This section of the questionnaire is an educational device as well as a diagnostic tool. It will help you to become familiar with the language of Oriental medicine and it will help me to evaluate you in terms of Eastern Medicine. Please check any symptoms you experience when not taking any medications or supplements to correct them. Circle and check those that have been most troublesome.

Patterns of Depletion

Yin Deficiency

___ warmer in afternoon or evening
___ heat in palms, soles, and chest
___ cheeks flushed, esp. in PM
___ symptoms worse at night *
___ dry throat, esp. at night
___ night sweating
___ restless/ irritable
___ hard to go to sleep (insomnia)
___ thirsty
___ dark, scant urine
___ dry constipation
___ feels like insides vibrating or humming
___ unstable blood sugar, lability
___ palpitations when anxious (HT)
___ restlessness
___ burning tongue tip
___ reddened palms
___ falling or staying asleep (insomnia)
___ dry, itchy red eyes (LR)
___ feelings of tightness around ribs
___ dry cough, worse at night (LU)
___ dry skin
___ dry stool
___ nocturnal emissions (KI)
___ brittle, sore, weak low back and legs
___ tremors in low body or legs
___ epigastric pain (ST)
___ dry mouth
___ increased hunger, worse at night *

Deficient Blood

___ pale face (not shiny)
___ pale lips
___ thinning of hair
___ dizzy when stand *
___ dizzy only when stand
___ poor memory
___ hard to stay asleep (insomnia)
___ anxious sleep
___ scant menstruation
___ restless fatigue
___ dryness without thirst
___ emotional sensitivity
___ anemia
___ muscle cramps
___ scanty or infrequent menstruation
___ poor skin healing
___ insufficient lactation
___ lack of semen
___ dry or hard stool
___ palpitations when at rest & not worrying (HT)
___ dream-disturbed sleep
___ anxiety
___ easily startled
___ dry skin, eyes, hair or nails (LR)
___ blurred or weak vision
___ floaters (spots in eyes)
___ scant menses
___ falling sensation as going to sleep

Deficient Qi

___ weak, lethargic, tired
___ excessive need for sleep
___ dull thinking or feeling
___ weak voice
___ perspire easily: with/without exertion
___ pale complexion
___ shortness of breath
___ loose stools
___ constipation
___ dizzy or weak after meal or bowel movement
___ feel worse after exertion *
___ lack of or lazy appetite
___ well-being followed by sudden exhaustion
___ susceptible to colds, flu, allergies
___ prolonged recovery following illness
___ easily chills
___ irregular heartbeat (HT)
___ palpitations when active
___ cough (LU)
___ feel tired after speaking *
___ feel worse after eating (SP/ST) *
___ bloating and gas after eating
___ weak limbs
___ nausea (SP + damp)
___ feel heavy
___ incontinence of stool or urine (SP qi sinking)
___ prolapsed organs, hemorrhoids, varicose veins
___ sore weak low back and legs (KI)
___ dribbling urination
___ nocturnal emissions
___ spermatorrhea
___ premature ejaculation
___ worse after sex *

Disturbed Shen (Spirit)

___ restless and agitated
___ hypersensitivity to pain or insult
___ sudden rage, grief, or panic
___ constant anxiety, worry, or confusion
___ easily startled or frightened
___ erratic sleep, insomnia, or disturbing dreams
___ dull, glazed or bizarre look to eyes and face
___ delirium

Deficient Yang

___ pale, bright face
___ cold
___ no thirst
___ desire for warm things
___ loose stools
___ frequent, copious urination
___ lethargic
___ palpitations (HT)
___ stuffiness or discomfort in chest
___ difficulty breathing
___ sore, weak low back (KI)
___ lack of sex drive
___ diarrhea first thing in the morning

Diminished Essence

___ profound weakness
___ atrophy of muscles and organs
___ sagging or wrinkling of skin
___ infertility or early menopause
___ repeated miscarriages
___ decline of memory, vision, or hearing
___ progressive loss of weight or emaciation
___ compromised immunity
___ poor memory
___ loosening or loss of teeth
___ early thinning or graying of head & pubic hair
___ decreased sexual arousal and pleasure
___ sore weak low back and legs
___ premature aging *

children:

___ poor or late development
___ physical or mental retardation
___ stunted growth *

Patterns of Excess

Blood Stagnation

___ sharp, stabbing or throbbing pain *
___ hard, immovable masses
___ broken blood vessels
___ menstrual clots
___ palpitations (HT)
___ sharp, stabbing pain in chest
___ feeling oppressed or constricted in chest
___ painful periods (LR)
___ irregular periods
___ clots or old, dark menstrual blood
___ 'masses' in abdomen
___ mottling, numbing and chilling of limbs
___ angina
___ severe or constant headache
___ traumatic bruises, swelling, and sprains
___ purple lesions of skin, tongue, mouth or lips
___ dark red or purple complexion

Qi Stagnation

___ dull or intermittent pain
___ hiccup, belching or flatulence
___ fluctuating moods
___ deep sighing
___ stuffy head
___ mild nausea or reflux
___ distention or fullness in chest or abdomen
___ gas pains or cramps in stomach or ntestines
___ abdominal bloating but cannot release gas
___ alternating diarrhea & constipation (usual)
___ masses that come and go
___ irregular menstrual cycles (LR)
___ painful periods
___ feeling of lump in throat
___ PMS
___ breast tenderness
___ irritability
___ digestive problems: churning, belching
___ nausea and/or vomiting
___ depression, anger, moodiness
___ rib pain

Damp

___ bloating
___ edema of hands, feet/ankles, or face/eyes
___ sticky diarrhea
___ heaviness in limbs or head
___ oily hair
___ sticky skin
___ worrier

Phlegm

___ literal phlegm or mucous strands *
___ fullness in head & chest
___ soft lumps
___ obsessive thoughts (chewing gum of mind)
___ mental confusion (HT)
___ unconsciousness

Heat

___ redness of eyes or face
___ feelings of heat
___ agitation
___ yellow or green discharges
___ dark & scant urination
___ constipation
___ mouth & tongue ulcers (HT fire)
___ bitter taste in mouth in AM *
___ pounding, red chest *
___ blazing behavior
___ bloody, or dark urine
___ insomnia with tossing & turning (active)
___ hellish dreams
___ bitter taste in mouth all day (LR fire) *
___ violent headache
___ irritability
___ dizziness
___ dry mouth
___ sudden tinnitus or deafness
___ hemorrhage
___ vomiting blood or other bleeding disturbances
___ burning sensation in epigastrium (ST)
___ desire for cold drinks
___ constant hunger
___ bleeding gums
___ sour regurgitation
___ nausea & vomiting
___ bad breath

Damp Heat

___ jaundice (LR/GB)
___ hypochondriac pain & distention
___ vaginal discharge
___ pain and redness in scrotum
___ problems breathing due to phlegm (LU)

Cold

___ feelings of coldness
___ pain & contraction
___ clear or white copious discharges
___ scrotal pain contraction (LR)
___ epigastric pain, better with warmth

Internal Wind

___ spasms, tics, tremors

From LR yin deficiency

___ unconsciousness
___ hemiplegia
___ deviated tongue, eye, mouth (stroke)
___ dizziness
___ seizures

From LR blood deficiency

___ numbness
___ quivery tongue
___ tics, tremors

Yang Rising from LR yin deficiency

___ anger or irritability
___ throbbing headache
___ dizziness
___ tinnitus
___ red face
___ dry, red eyes

External Wind

___ itching or prickling sensations of skin, ears, nose; sneezing, headache
___ unpredictable or migrating pains
___ dizziness or headache with cold, flu, or allergy
___ muscle soreness or shivering in winds or drafts
___ numbness or pain of face or scalp
___ neck stiffness or spasm
___ worse from drafts, changing temperatures, pressure

Any other aches, pains, symptoms, traumas, or experiences you wish to make note of:

_____

_____

_____

_____

I understand that appointments not cancelled at least 24 business hours in advance will be charged to me.._____
Initials

Signature _____ Da te: _____

Thank you for taking the time to complete this intake. It will enable us to work together to better serve your needs and help you meet your goals.

Acupuncture for Harmony

CONSENT TO TREATMENT

I, _____, voluntarily consent to be treated with Acupuncture. I understand that the Acupuncture will be performed by the insertion of sterile, disposable needles through the skin, or by application of heat, or by some combination of the foregoing, at certain points on my body; and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, side effects may result from my Acupuncture treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea, and the temporary aggravation of pre-existing conditions.

I accept that No Guarantee is made concerning the results of my Acupuncture treatment, and I have been informed that I may stop treatment at any time.

RELEASE OF INFORMATION

I consent to the use and disclosure of my protected health information for treatment, payment and/or clinic operations. I understand that I have the right to revoke this consent, in writing, at any time. However, revocation will not affect any disclosures made in reliance of my prior consent.

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

I acknowledge that I have been given access to a copy of the Notice of Privacy practices and Patient Rights and have had the opportunity to ask questions about it. All questions I have asked have been fully answered.

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Guardian Date Signed

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