

Welcome to Jade Blossom Acupuncture

To help us provide you with the best possible care, please fill out this form as accurately as you can. All the information provided here will be held in strictest confidence. Feel free to ask if you have any questions.

Name _____ Age _____ Today's date _____

Address _____ City _____ Zip _____

Gender _____ Marital status _____ Birthday _____ Work phone (_____) _____

Employer _____ Home phone (_____) _____

Occupation _____ Do you like your job? _____ Cell phone (_____) _____

Height _____ Weight _____ Referred by _____

Please initial here to give your permission for us to thank the person who referred you to our office _____

Emergency contact _____ Relationship & Phone _____

Have you received acupuncture therapy before? _____ Email address _____

Chief Complaint _____

Please rate your current pain or discomfort on a scale of 1 to 10:

Very slight 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes it feel better? _____ Worse? _____

Who else have you seen for this condition? _____

Please sign here if I may contact them regarding your case _____

Medical History (include dates). Surgeries _____

Describe any scars _____

Major illnesses _____

Significant trauma (emotional or physical) _____

Allergies _____

Medications, vitamins, & herbs taken within the last 3 months—please include reason, date, & dosage:

Occupational stress (chemical, physical, psychological) _____

Please check any that apply: tobacco coffee green/black/iced tea soft drinks/diet soft drinks
 alcohol artificial sweeteners recreational drugs

How many glasses of water do you drink daily? _____ glasses Blood type _____

Exercise (please describe) _____

Family Medical History (please check, and indicate affected family member)

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Alcoholism/Addiction | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Prostate Disorders |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Depression/Mental Disorders |

Please check any of the following that applies to you:

- | | | |
|---|---|---|
| <input type="checkbox"/> Loose stools or diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Belching | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Lack of appetite |
| <input type="checkbox"/> Feeling of retention of food in stomach | <input type="checkbox"/> Diabetes or hypoglycemia | <input type="checkbox"/> HIV positive or AIDS |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Prolapsed organs | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Tendency to become obsessive in your work or relationships | | <input type="checkbox"/> Suicidal feelings |

- | | | |
|---|---|--|
| <input type="checkbox"/> Insomnia (what time?) _____ | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Dream-disturbed sleep/nightmares | <input type="checkbox"/> Anxiety (attacks) | <input type="checkbox"/> Easily startled |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart racing | <input type="checkbox"/> Irregular heartbeat |

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches/migraines (where and when) _____ | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Spots before eyes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Shingles | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Shoulder or neck tension | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Difficult bowel movements | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Impatience |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Soft or brittle nails | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fullness/pain behind ribs | <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Easily angered |

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Sadness/Grief |
| <input type="checkbox"/> Sinus congestion/infections | <input type="checkbox"/> Shallow breathing | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weak voice |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Recent use of antibiotics | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Nasal discharge: <input type="checkbox"/> Clear <input type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> Bloody <input type="checkbox"/> Thick <input type="checkbox"/> Thin and watery | | |
| <input type="checkbox"/> Skin problems: _____ | | |

- | | | |
|--|--|---|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Weak knees |
| <input type="checkbox"/> Edema or swelling | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Prostate disorders |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Urinary disorders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Teeth/gum problems | <input type="checkbox"/> Reduced sexual energy | <input type="checkbox"/> Fearfulness |
| <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> No energy to speak | <input type="checkbox"/> Lack of strength |
| <input type="checkbox"/> Dislike physical movement | <input type="checkbox"/> General physical weakness | <input type="checkbox"/> General fatigue |

Blurred vision Dry, brittle hair Poor memory
 Skin rashes Numbness (where) _____

 Aversion to cold Cold hands and feet Easily chilled
 Frequent clear urination Lack of thirst Desire for hot drinks
 Frequently thirsty Hot hands and feet Night sweats
 Low-grade afternoon fever Dry throat Red, flushed cheeks
Other _____

Gynecological

Is there any possibility that you are pregnant? Yes No Birth control _____

Pregnancies _____ # Births _____ # Miscarriages _____ # Abortions _____ # C-sections _____

Menstrual flow: Heavy Light Clots Painful Color of menses _____

No. of days between periods _____ Length of period _____

Date of last period _____ Date of last PAP _____ PAP results _____

Age at first menses _____ Spotting between periods Vaginal sores _____

PMS: Breast tenderness Bloating Moodiness Irritability Weepy Cramps (before/during/after)

Other _____

Perimenopausal: Skipped/irregular periods Hot flashes Moodiness Vaginal dryness

Menopause/age: _____ **Hysterectomy/age and reason:** _____

Vaginal discharge (describe) _____

Breast lumps/cysts _____ Endometriosis/When: _____

Other _____

Other

What is your favorite season? _____ Least favorite? _____

How would you describe your overall emotional state? _____

Please let us know if there are any other issues that you would like to discuss: _____

For Your Information—please read and sign.

- 1) Only sterile, disposable needles are used at Jade Blossom Acupuncture.
- 2) Occasionally you may get a small hematoma (a little bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern—it will go away after a few days. Gentle pressure applied to the site will stop any small amount of bleeding that is occurring under the skin.

- 3) Herbal prescriptions and herbal patent medicines are intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.
- 4) After receiving an acupuncture treatment, you may feel a little light-headed. If so, please have a seat in the reception room or take a short walk around our building. In a few minutes, you will feel relaxed and clear-headed.
- 5) Please do not wear cologne, perfume, or strongly scented lotion on the day of your appointment with us. Many of our clients are allergic or sensitive to them.

I have read the above information. I hereby request to be treated with acupuncture and/or Chinese herbal medicine for my condition.

Signature _____ Date _____

The following documentation is required by law pursuant to the Texas Revised Civil Statutes, Article 4495, Medical Practice Act of Texas, Subchapter F., regarding Acupuncture Practice, Sec. 6.11, subsections (b) through (d):

Please read and check the appropriate answers:

- 1) I have been evaluated by a physician or dentist for the condition being treated within the last twelve months prior to having acupuncture performed. Yes No
- 2) I have received a referral from my chiropractor within the last 30 days for acupuncture. Yes No
- 3) I am here for one of the following conditions:

<input type="checkbox"/> Weight control	<input type="checkbox"/> Smoking cessation
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Chronic pain

I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist. In being referred by my chiropractor, if after 120 days or 30 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

Signature _____ Date _____

If you answered **no** to all of the above questions, I, Julie Luker, am requesting that you see a physician prior to receiving acupuncture. It is your responsibility and your choice whether to follow this advice.

Jade Blossom Acupuncture
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