

OJAS

wellness center

ACUPUNCTURE PATIENT INTAKE FORM

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION:

Name _____ Sex M ___ F ___ Date _____ Email _____

Address _____ City _____ State _____ Zip _____

Telephone: Home () _____ Work () _____ Cell () _____

Date of Birth _____ Age _____

Single ___ Married ___ Separated/Divorced ___ Widowed ___ Partnered ___

How did you learn about us? (Please check one)

Friend/Referral PLEASE PRINT NAME (Friend will receive Wellness Reward points)

Walk In/Drive-By Advertisement Phonebook Other: _____

Preferred Method Of Future Appointment Confirmations:

Email Text Email & Text

For text confirmation, please check:

Verizon Sprint

AT&T Other _____

Education _____

Occupation _____

Employer _____

Emergency contact _____

Relation _____

Emergency contact telephone: Home () _____ Cell () _____

Name of physician * _____

Address of physician _____

Phone number of physician () _____

Date of last physician appointment _____

Date of last gynecology exam (women only) _____

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? Yes/No

* No contact will be made with the physician without your permission.

FAMILY HISTORY – Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse	children
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Seizures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Deceased (age)	n/a					
Hepatitis						
Kidney disorders						
Thyroid disorders						
Musculoskeletal disorder						
Blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

MEDICAL: If you have ever been hospitalized for a serious medical illness or operation, please write the most recent ones below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

MEDICINES:

What prescription drugs are you currently taking:

For what condition?

What over-the-counter medications, herbs, or supplements are you currently taking:

For what condition?

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General

- Insomnia
- Dreams/ nightmares
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Hearing aids
- Infections
- Earache
- Vertigo

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

Nose, Throat & Mouth

- Sinus infection
- Hay fever/ allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems

- Dry mouth

Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easily bruised
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing when reclining
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas

- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool

Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain (describe)
- Paralysis
- Poor coordination
- Other (describe)

Mental/Emotional

- Depression
- Mood swings
- Irritability
- Difficulty relaxing
- Loneliness
- Sensitive
- Shy
- Cry often
- Worry a lot
- Compulsive behaviors
- Difficulty focusing
- Hopeless outlook
- Suicidal thoughts
- Lose temper
- Frustration

Urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting

- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones

Male Genital

- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

Gynecology (Women Only)

- Currently pregnant
- # of Pregnancies
- Miscarriages

- Abortions
- Menopause
- Hormone replacement therapy
- Irregular periods
- Menstrual cramps
- Excessive blood flow
- Menstrual blood clots
- Breast tenderness
- Abnormal pap smear
- Vaginal infections
- Vaginal pain/itching
- Uterine fibroids
- Endometriosis
- Breast lumps, cysts

Infection Screening (circle self and/or partner)

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea: self or partner
- Chlamydia: self or partner
- Syphilis: self or partner
- Genital warts: self or partner
- Herpes: oral/genital: self or partner

Other Information

Ojas Policies:

Appointments – A client’s appointment for acupuncture, massage and bodywork can be made by telephone or in person using your Visa, Mastercard, Discover, or American Express.

Guest Cancellations – Because of our high demand and premium service, we request the courtesy of a 24-hour cancellation notice for all acupuncture, massage, and bodywork appointments. Cancellations of less than 24-hours will be charged a 50% fee to the client’s credit card, and no shows will be charged a 100% fee. Gift certificates will be reduced to half value, and clients with a massage package will be charged one unit of that package.

Late Arrivals – We regret late arrivals will not receive an extension of scheduled service times and will be responsible for the full service fee.

Client Confirmation - Ojas will contact clients via email and/or text message as indicated above for appointment confirmation approximately 48 hours prior to the appointment.

Please feel free to give feedback to the acupuncturist during and after each session. Each person is unique and only through open communication can we maximize the acupuncture treatment for you.

I do forever release Ojas Wellness Center, the practitioners and their insurers, from all liability of any nature whatsoever, whether past, present, or future for injury or damage which may occur. I agree to hold harmless and defend Ojas Wellness Center and the practitioner of and all actions, claims, or other legal or administrative action that has arisen or may arise from my participation in this service.

I have read and understand the above information and policies and have provided all requested information to the best of my knowledge. I understand that acupuncture treatment does not constitute medical treatment. I take full responsibility for alerting the acupuncturist of any conditions that arise which may affect the acupuncture session. I voluntarily agree to the terms and conditions stated above.

Signature _____

Date _____

