Date: _____

Eastern Vitality
ACUPUNCTURE

Name: _____ Date of birth: _____

Age: _____ Gender _____ Occupation: _____

Street Address_____ Home Phone: _____

City, State, Zip: _____ Cell Phone:_____

E-mail: _____ Work Phone: _____

Emergency Contact: _____ Relationship to you: _____

Address: _____ Home phone: _____

Cell Phone: _____ Work phone: _____

May we thank someone for referring you, or how did you hear of us? _____

Have you ever received acupuncture? _____ If yes, where? _____

For what conditions? _____

What are you seeking treatment for today?_____

Please indicate if any of the following pertain to you:
☐Hepatitis (A,B,C,) ☐HIV ☐ High Blood Pressure ☐ Seizures

HEALTH HISTORY

What are your most important health concerns? Please list in order of importance:

1._____ Date of Onset: _____
2. _____ Date of Onset: _____
3. _____ Date of Onset: _____

Date of last physical exam: _____ Physician: _____
Physician's phone: _____

Please list any hospitalization and/or surgeries :

Hospitalization/surgery	Date	Reason

Please list any injuries and/or accidents:

Accident/injury	Date	Relation to health

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc):

Name	Dosage	Reason for taking	Date began taking

Please indicate if you are taking any of the following:
☐blood thinners (warfarin, Coumadin, etc.) ☐ diet pills (diuretics, appetite suppressants, etc.) ☐pain relievers (Tylenol, aspirin, etc.) ☐cortisone or other steroids ☐thyroid medication ☐tranquilizers/sedatives ☐ sleeping aids ☐laxatives ☐antacids (Tums, etc)

Approximately how many courses of antibiotics have you taken over the past 10 years?

_____

Please review the following symptoms and mark an X in the appropriate column.
Leave blank if you do not experience the symptom.

	Occasional	Frequent		Occasional	Frequent
cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in work or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
irritability			hearing impairment		
bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			decreased sex drive		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			foggy headed		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
change in weight			numbness/tingling		
nose bleeds			pain on urination		
ear aches or infections			athlete's foot		

Do you have a bowel movement every day? ☐yes ☐ no
Number of bowel movements per day? _____
Are your BMs:
☐Well formed ☐Soft ☐Ribbon-like ☐Loose ☐Contains undigested food ☐Bad smelling
☐Burning upon defecation ☐Burning/heaviness in rectum ☐Incomplete BMs

LIFESTYLE HISTORY

Height _____ Weight: _____ Do you exercise? _____
How many times a week? _____
What type of exercise? _____
Do you drink coffee/black tea? _____ # 8 oz cups per day/week? _____
Do you drink soda _____ Is it caffeinated? _____#12 oz glasses per day/week? _____
How much water do you drink per day? _____
Please describe your typical diet:
Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

meals per day: _____ # snacks per day: _____ How often do you eat out (or order in)? _____
Are you vegetarian, vegan, kosher? Are there other restrictions to your diet?_____
Do you experience any gas, burping, bloating acid reflux or other digestive symptoms after eating any foods?

_____

Do you use tobacco? _____ How many times per day/week? _____
Have you used tobacco in the past? _____ When did you stop? _____
Do you drink alcoholic beverages? _____
How many drinks do you have per day/week? _____
Do you use recreational drugs? _____
How many times per day/week/month/year? _____
Have you been treated for drug/alcohol addiction? _____
hours you sleep per night: _____ Do you sleep well? _____
Do you awake feeling rested? _____
What is your average stress level (*1 is low, 10 is high*)? 1 2 3 4 5 6 7 8 9 10
What is your average energy level (*1 is low, 10 is high*)? 1 2 3 4 5 6 7 8 9 10
At what time of day is your energy typically at its best? _____ At its worst? _____

How do you feel about the following areas of your life?

	great	**good**	**fair**	**poor**	**bad**
significant other					
family relations					
friendships					
living arrangements					
self image					
sex					
work					
vacations/time off					
exercise					
spirituality					

How much change are you willing to/able to make at this time to improve your health?
(Please circle) Minimal Some Complete

FAMILY HISTORY

Please indicate whether you or any family member has, or has ever had any of the following conditions:

Disorder/Illness	Which family member (include yourself; give important details)	Date
Alcoholism/addictions		
Allergies/asthma		
Alzheimer's disease		
Anemia		
Arthritis		
Autoimmune disorders		
Bell's Palsy		
Birth defects		
Bleeding disorders		
Blood clots		
Cancer (specify type)		
COPD		
Crohn's disease		
Depression/anxiety		
Diabetes		
Epilepsy		
Fibromalygia		
Gallbladder problems		
Glaucoma		
Heart disease		
Heart murmurs		
Hepatitis		
High cholesterol		
High blood pressure		
HIV/AIDS		
Infectious disease		
Infertility		
Irritable bowel		
Kidney disease		
Kidney stones		
Mental illness		
Osteoporosis		
Pacemaker/defibrillator		
Polycystic Ovary		
Restless Leg		
Shingles		
Stroke		
Thyroid dysfunction		
Tuberculosis		
Ulcers		
Urinary tract infections		
Yeast infections		

INFORMED CONSENT

This is to inform you that Acupuncturists are not licensed to practice medicine in the state of Illinois; an Acupuncturist is not making a medical diagnosis of your medical condition; if you want to obtain a medical diagnosis, contact a licensed Medical Doctor.

I understand that acupuncture involves placing sterilized, one-time use, disposable needles through the skin, which can produce a mild, but temporary discomfort, at the acupuncture site. It can occasionally cause slight bleeding and rarely, but occasionally, leaves a bruise. Other possible risks from acupuncture include dizziness and fainting or light-headedness. I will report to my Acupuncturist if I feel any of the aforementioned symptoms during or after an acupuncture treatment. Extremely rare risk of acupuncture includes nerve damage, organ puncture and infection.

My Acupuncturist may use liniments (herbal ointments), gua sha (muscle scraping technique), cupping (myofacial release), moxa (heat therapy), and electro-stimulation and Chinese herbs, as appropriate to treatment.

By signing below, I show that:

- I have read and understand the possible risks and complications involved in treatment. I have had the opportunity to discuss this consent form with my Licensed Acupuncturist. I understand I can request more information at any time, if desired.
- I consent to receiving treatment that involves the above procedures.
- I understand that I have the right to refuse or discontinue treatment at any time.

Patient or Guardian's Signature_____**Date**_____

Practitioner's Signature_____**Date**_____

Acupuncture Late Cancellation/No Show Policy

Please contact us at least 24 hours in advance to cancel or reschedule your acupuncture appointment. We enforce a strict cancellation policy and you will be charged the full amount for your scheduled appointment time if cancellation or rescheduling is less than 24 hours. If we do not receive sufficient notice or you do not show for your appointment, you will be charged the full fee for the treatment. We appreciate your understanding and cooperation with our policies.

I, _____, have read the above policy and acknowledge I will be charged the full amount and am responsible for payment for the above mentioned circumstances. My card will be on file and charged the same day of my scheduled appointment.

_____
Signature

_____
Printed Name of Policyholder

_____ _____ _____ _____
Credit Card Number *Exp. Date* *CVV Code* *Billing Zipcode*

**Your credit card information will be stored in a secure site and you will be notified of any charge placed to meet the policies above.*

SMS Text Appointment Reminder Consent

I agree to allow Eastern Vitality LLC to send SMS text appointment reminders to my mobile phone number two days, and three hours prior to my scheduled appointments. I understand that standard data and message rates may apply to this service. If I choose to cancel this service I will contact Eastern Vitality LLC via phone email to cancel my enrollment. Lastly, I understand that this agreement to receive text messages is not a condition of purchasing a good or service.

_____
Signature

(_____)_____-_____
Mobile Number