Acupuncture at Morningstar Chiropractic and Wellness

New Patient Intake Form

DATE: _____

Name:_____ ❑ Male ❑ Female Birthday:_____ /_____/_____

Marital Status: _____ Age:_____ Ht_____ Wt_____

Address:_____ City: _____Zip:_____

Contact Phone: Cell (_____)_____ Home (_____)_____

Emergency Contact (Name & Phone)_____Occupation/Employer:_____

Referred by_____ Have you had Acupuncture before? ❑ Yes ❑ No

Reason for today's visit_____

How long have you had this condition?_____

Does it bother: ❑ Sleep ❑ Work ❑ Other _____

What seems to make it **better**? _____ **Worse?**_____

Is this related to Auto Accident or work injury? ___ If Auto, PIP or PI?_____ Date of accident_____

If work related, L&I or company liability?_____

Are you currently under the care of a physician? ❑ Yes ❑ No If yes, for what?_____

Who is your physician?(name & phone):_____

**Current medications:_____

_____

Please check ✔ if YES to any of following Medical conditions:

(Check any of the following conditions you currently have, or have had in the past 3 months, OR significant part of medical history)

❑ Asthma ❑ Stroke ❑ Pacemaker ❑ Pregnant
❑ Alcoholism ❑ Allergies ❑ Surgery List:_____

OTHER MAJOR MEDICAL CONDITIONS- please list

_____

LIFESTYLE

❑ Alcohol	❑ Marijuana	❑ Stress	❑ Regular Exercise	
❑ Tobacco	❑ Recreational habits	❑ Occupational Hazards	Type:	Frequency:

GENERAL SYMPTOMS

❑ Poor or heavy appetite	❑ Poor sleep	❑ Bodily heaviness	❑ Chills	❑ Bleed or bruise easily
❑ Stress	❑ Heavy sleep	❑ Cold hands or feet	❑ Night sweats	❑ Peculiar taste (describe)
❑ Prefer cold drinks	❑ Dream disturbed sleep	❑ Poor circulation	❑ Sweat easily	_____
❑ Prefer hot drinks	❑ Fatigue	❑ Shortness of breath	❑ Muscle cramps	❑ Usually feel cold
❑ Weight gain or loss	❑ Lack of strength	❑ Fever	❑ Vertigo or dizziness	❑ Usually feel hot

HEAD/EYES/EARS/NOSE/THROAT

❑ Glasses	❑ issues with mouth	❑ Spots in eyes	❑ Sore throat	❑ Headaches
❑ Eyestrain	❑ hearing problem	❑ Red eyes/itchy eyes	❑ Nose bleeds	❑ Other head or neck problems

❑ Eye pain ❑ TMJ/grinding teeth ❑ Sinus problems ❑ Enlarged thyroid _____

RESPIRATORY ❑ Bronchitis ❑ Pneumonia ❑ Shortness of breath ❑ Asthma/wheezing
❑ Cough
Productive? _____

CARDIOVASCULAR
❑ Blood pressure H/L ❑ Irreg.heartbeat o Palpitations ❑ Fainting ❑ Chest pain ❑ Blood clots ❑Take blood thinners

GASTROINTESTINAL
❑ Nausea ❑ Diarrhea ❑ Intestinal pain/cramp Bowel movements:
❑ Vomiting ❑ Constipation ❑ Rectal pain Frequency _____
❑ Acid regurgitation ❑ Laxative use ❑ Hemorrhoid
❑ Gas ❑ Bloating ❑ Bad breath

MUSCULOSKELETAL
❑ Neck/shoulder pain ❑ Upper back pain ❑ Joint pain ❑ Limited range of motion ❑ Other (describe)
❑ Muscle pain ❑ Low back pain ❑ Rib pain ❑ Limited use _____

SKIN/HAIR
❑ Rashes ❑ Eczema ❑ Acne ❑ Ulcerations ❑ Other hair or skin problems:
❑ Hives ❑ Psoriasis ❑ Change in skin texture ❑ Fungal infection _____

NEUROPSYCHOLOGICAL
❑ Seizures ❑ Poor memory ❑ Irritability ❑ Considered suicide ❑ Eating Disorder
❑ Numbness ❑ Depression ❑ Anxiety ❑ Tics ❑ Other (describe)
_____

GENITO-URINARY
❑ Kidney stone ❑ Premature ejaculation ❑ Venereal disease ❑ Erectile Dysfunction ❑ Bedwetting
❑ Hepatitis A/B/C____
❑ HIV____ ❑ HPV/genital warts

GYNECOLOGY
❑ Age menses began _____ ❑ Duration of flow _____ ❑ Vaginal discharge (color) _____ ❑ Breast lumps # Pregnancies_____ Date of last PAP _____
❑ Length of cycle _____ ❑ Irregular periods ❑ Vaginal sores # Births_____
❑ Painful periods ❑ Vaginal odor Premature births_____ Date last period began ____
❑ Clots ❑ PMS Age at Menopause_____

Office Policies and Authorization for Treatment

I, _____, understand that acupuncture is a form of therapy that is not intended to replace conventional medical treatment. I assume full responsibility for consulting with the appropriate physician, with the understanding that any diagnosis of my condition must be performed by a licensed physician.

I hereby authorize Sarah DeLaForest, LAc to perform the following specific procedures:
Acupuncture procedures involving insertion of special needles through the skin into the underlying tissue at specific points on the surface of the body, as well as other techniques as specifically described by the Minnesota Board of Medical Practice, such as cupping, electro-acupuncture, and acupressure.

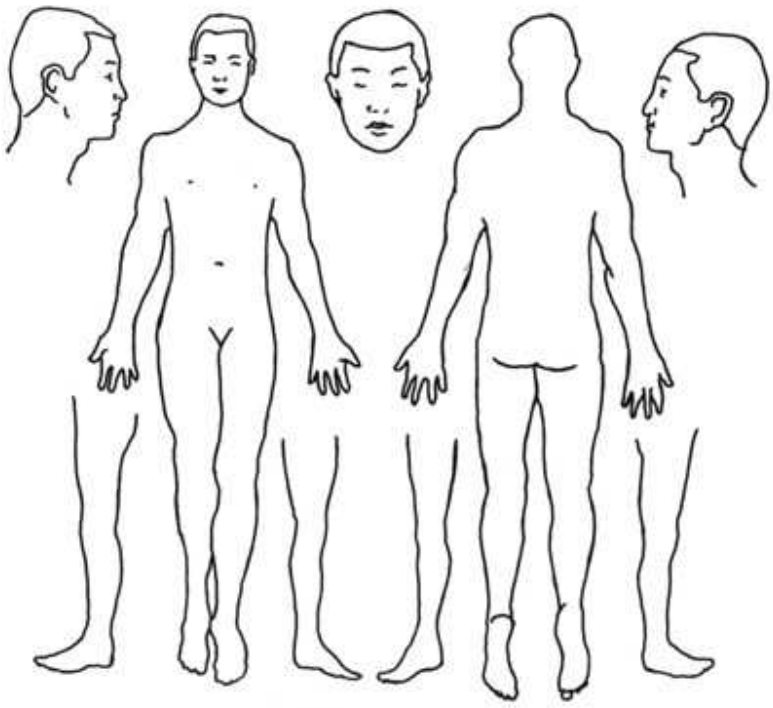
Potential Benefits: Relief of my presenting symptoms and improved function/regulation of various body systems, which may to elimination of the presenting problem and prevention of this and other issues in the future.
Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruising, weakness, fainting, nausea, and even aggravation of symptoms existing prior to the acupuncture treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given me by Sarah DeLaForest, LAc regarding cure or improvement of my condition. I hereby release Sarah DeLaForest, LAc, from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

_____ _____
Signature of Patient Date

_____ _____
Signature of Person Authorized to Consent Date

☯Pain patients, please indicate on the image below, the area(s) in which you experience your pain.



☯Pain characteristic(s): O aching O burning O cold O dull O hot O electric O heavy O numb O sharp O stabbing