ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic
The Springs Integrative Medicine Center and Spa

Acupuncture Intake Form

Name _____ **Date of Birth** _____ **Today's Date** _____

What reasons are you seeking acupuncture treatment? _____

_____

Who is your Primary Care Doctor? _____

Please list names of any Specialists you see: _____

For WOMEN, are you pregnant or trying to become pregnant? ☐YES ☐NO If Yes, #_____ weeks gestation

What is your blood type? _____ **Do you have a bleeding disorder?** _____

What are your major sources of stress? 1 _____ 2 _____
3 _____ 4 _____ 5 _____ 6 _____

MEDICATIONS – Do you take/use any of the following medications?

Please list prescription & over the counter medications:	**Please list Herbs, supplements, vitamins, etc:**

ALLERGIES

Drugs/Medications	☐YES ☐NO	Specify:
Gluten	☐YES ☐NO	Specify:
Iodine/Seafood	☐YES ☐NO	Specify:
Other Foods	☐YES ☐NO	Specify:
Plants/Environmental	☐YES ☐NO	Specify:
Other	☐YES ☐NO	Specify:
Skin sensitivities/reactions to products/ingredients	☐YES ☐NO	Specify:

MAIN MEDICAL HISTORY (Please include dates):

Medical Diagnoses:
Surgeries:
Injuries:

GENERAL (CHECK ALL THAT APPLY)

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Cancer
- ☐ Lymph Nodes Removed
- ☐ Rheumatic Fever
- ☐ Alcoholism
- ☐ Hepatitis A/B/C
- ☐ Lyme Disease
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Birth Trauma
- ☐ Diabetes
- ☐ Autoimmune Dis.
- ☐ Herpes
- ☐ High/Low thyroid
- ☐ Seizures
- ☐ Pacemaker
- ☐ Varicose Veins
- ☐ Other _____

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DIET

Food Cravings ? _____
Food Intolerances? _____

How many glasses/cups do you drink each day of the following:
Water _____ Soda _____ Coffee _____ Tea _____ Alcohol _____

How much of the following do you consume (# servings) per day/week:
Meat _____ Sugar/Sweets _____ Dairy/Milk/Cheese/Yogurt _____

Do you perspire during the day? ☐YES ☐NO
Do you perspire at night? ☐YES ☐NO

Are you always thirsty? ☐YES ☐NO
Do you prefer hot or cold drinks? ☐HOT ☐COLD

Taste Preferences – Rank the following according to your preference for each (Indicate 1-5 w/ 1=MOST LIKED -- 5= DISLIKED
Salty _____ Sour _____ Bitter _____ Sweet _____ Spicy _____

GASTROINTESTINAL (CHECK ALL THAT APPLY)

- □ Belching
- □ Nausea
- □ Vomiting
- □ Ulcers
- □ Indigestion
- □ Hernia
- □ Hemorrhoids
- □ Acid Reflux

Bowel Movements – how often? _____ day/week

- □ Irregular
- □ Constipation
- □ Diarrhea
- □ Gas
- □ Burning
- □ Bloating

EXERCISE & ENERGY (CHECK ALL THAT APPLY)

What kind of exercise do you engage in? _____ How often? _____
How is your energy level? _____
Do you have periods of low energy? _____

EMOTIONS & SLEEP (CHECK ALL THAT APPLY)

- □ High Stress
- □ Panic Attacks
- □ Depression
- □ Anxiety
- □ Nerves
- □ Fear
- □ Grief
- □ Poor Memory
- □ Difficulty Concentrating
- □ Other _____

Do you take antidepressants? ☐YES ☐NO
If yes, what kind? _____

Other Medications for Emotions? _____

- □ Difficulty Falling Asleep
- □ Disturbed Sleep
  - □ due to dreams
  - □ due to night sweats
  - □ due to pain
- □ Waking up @ ____am/pm
- □ Restless

Do you take sleeping pills? ☐YES ☐NO
If yes, what kind? _____

URINARY & GYN (CHECK ALL THAT APPLY)

How often do you urinate? _____ times per day. Color: _____

- □ Frequent urination
- □ Blood/pus in urine
- □ Incontinence
- □ Kidney stones
- □ Burning
- □ Bladder Infections

For MEN:

- □ Low Libido
- □ Prostate issues
- □ Premature ejaculation
- □ Impotence
- □ Low sperm count

For WOMEN:

Are you still menstruating? ☐YES ☐NO
Are you peri-menopausal? ☐YES ☐NO
Symptoms: _____
Are you menopausal? ☐YES ☐NO
Symptoms: _____

- □ Heavy Flow
- □ Light Flow
- □ Uterine Fibroids
- □ Blood Clots
- □ PMS
- □ Painful Periods
- □ Cystic Breasts
- □ Low libido

# of pregnancies _____# of births _____
Any complications during pregnancy or labor?_____

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RESPIRATORY, ENT & HEAD (CHECK ALL THAT APPLY)

Do you smoke? ☐ YES ☐ NO If yes, _____ times/day for _____years

- ☐ Frequent Colds
- ☐ Asthma
- ☐ Dizziness
- ☐ Emphysema
- ☐ Ear Pain
- ☐ Ringing in ears
- ☐ Clogged/popping ears
- ☐ Tuberculosis
- ☐ Frequent Headache
- ☐ Tension Headache
- ☐ Migraine
- ☐ Sinus Headache
- ☐ Cold Sores
- ☐ Bleeding Gums
- ☐ Dry Mouth

CARDIOVASCULAR (CHECK ALL THAT APPLY)

- ☐ Palpitations
- ☐ Varicose Veins
- ☐ High or Low blood pressure
- ☐ Spider Veins
- ☐ Cold Hands/Feet
- ☐ Heart attack
- ☐ Mitral Valve
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Irregular Heartbeat
- ☐ Chest Pain
- ☐ Swelling of ankles

SKIN & HAIR (CHECK ALL THAT APPLY)

- ☐ Dry Skin
- ☐ Skin rashes
- ☐ Bruise easily
- ☐ Itching
- ☐ Acne
- ☐ Slow healing sores
- ☐ Eczema
- ☐ Hives
- ☐ Sensitive skin
- ☐ Hair Loss
- ☐ Boils

PAIN/ORTHOPEDIC (CHECK ALL THAT APPLY)

- ☐ Tremors
- ☐ Cramping
- ☐ Neuralgia
- ☐ Weakness in arms or legs
- ☐ Numbness/tingling _____
- ☐ Bell's palsy

PAIN:

- ☐ Neck
- ☐ Upper/Mid back
- ☐ Low back
- ☐ Legs
- ☐ Sciatica
- ☐ TMJ/jaw pain
- ☐ Shoulders
- ☐ Hands/wrists
- ☐ Feet/ankles
- ☐ Hips
- ☐ Other _____
- ☐ Headaches
  - ☐ Migraines
  - ☐ Tension
  - ☐ Sinus
- ☐ Face

Are there any additional health conditions/concerns I should be aware of? _____

_____

_____

The information I have provided is true and complete to the best of my knowledge. I agree to inform my practitioner of any changes in my health prior to treatment.

_____ _____

Patient Signature Date

FOR PRACTITIONER USE:

Initial Assessment Observations/Notes: _____

_____

_____

_____

_____

_____

_____ _____ _____

Practitioner Signature Date Time

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_____ _____
Patient Name (Please print) **Date of Birth**

Consent for Acupuncture

1. I hereby authorize Mary Sarratori, Licensed Acupuncturist, at Clifton Springs Hospital and Clinic to perform acupuncture and/or other procedures associated with oriental medicine upon me or the named patient. I understand that acupuncture is a technique used to relieve pain in a specific area of the body.
2. I am aware that methods of treatment may include, but not be limited to acupuncture, moxibustion (use of heated mugwort near certain acupuncture points), cupping (use of warm air in glass jars on areas of the body), massage, electrical stimulation, nutritional counseling and herbal medicine.
3. Some acupuncture points and herbal medications should not be used during pregnancy. Therefore, I agree to notify Mary Sarratori if I believe I may be pregnant.
4. I further agree to notify Mary Sarratori if I am diabetic, since the decreased sensation that is frequently associated with diabetes may increase the likelihood of burns, blisters or other injury from moxibustion, cupping or insertion of acupuncture needles.
5. Mary Sarratori has fully explained to me the purpose of acupuncture and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. The risks discussed include, but are not limited to: allergic reaction to herbal medications and/or mugwort; bruising, numbness and tingling at the sites where acupuncture needles are inserted; burns and blisters from moxibustion, and bruises or non-permanent skin marks from cupping. I agree to notify Mary Sarratori if I experience any unpleasant or unanticipated side effects from my acupuncture treatment.
6. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
7. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from acupuncture. In addition, potential problems that might occur during recuperation have been explained to me.
8. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above that do not pertain to me.

_____ _____ _____
Signature Patient/Relative/Guardian* Print Name Date

_____
Relationship to Patient

**The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.*

Patient Advisory to Consult Physician

As an acupuncturist, I believe strongly in and am committed to oriental medicine. However, I recommend that you consult with your physician regarding any condition or conditions you have prior to seeking acupuncture treatment. **State law requires that you read and sign the following statement:**

We, the undersigned, do affirm that (Print Patient Name) _____ has been advised by Mary Sarratori, LAc., to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

_____ _____ _____
Patient's Signature Acupuncturist's Signature Date