Free Flow Health Acupuncture

Acupuncture Intake Form
All Information is Strictly Confidential

Name_____ Date of Birth_____

Address_____City/State/Zip_____

Phone:H)_____ W)_____ C)_____

Email _____Occupation_____

Whom may we thank for your referral? _____

Please take a moment to answer the following questions:

Have you had acupuncture treatments before? ❑Yes ❑No *When?* _____

What are your particular goals for this acupuncture session?

_____

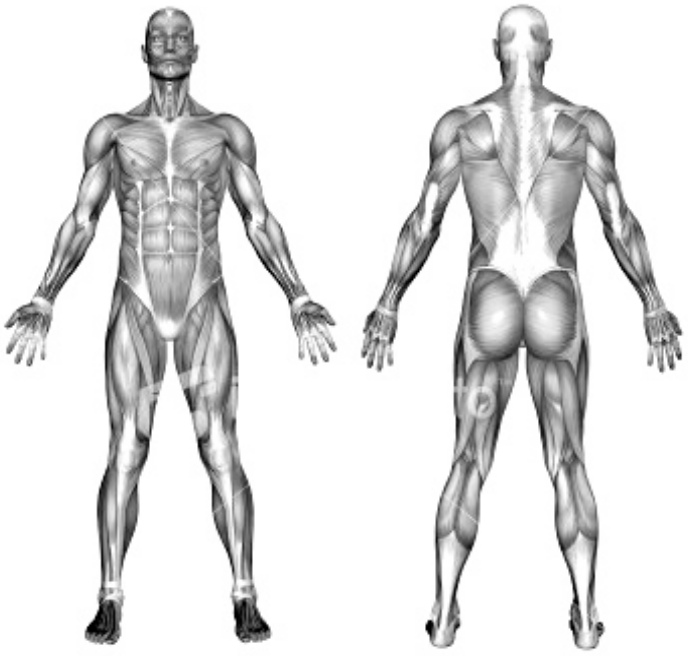
Do you frequently feel stressed? ❑Yes ❑No

How would you describe your current state of health? _____

When do you last remember feeling really great? _____

Are you currently pregnant or breastfeeding? ❑Yes ❑No

Please mark on the figures below where you are experiencing any discomfort, pain, or tension.



4002 Park Blvd. ⚹ San Diego, CA. 92103 ⚹ tel: 619-793-7030
www.freeflowhealth.com

Are you currently under the care of any of the following medical professionals?

- ❑ Medical Doctor
- ❑ Chiropractor
- ❑ Acupuncturist
- ❑ Physical Therapist
- ❑ Naturopath
- ❑ Massage Therapist
- ❑ Nutritionist
- ❑ Psychiatrist
- ❑ Personal Trainer

Please check any that apply:

Musculoskeletal System
- ❑ Arthritis
- ❑ Artificial Joint
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Joint Pain
- ❑ Muscular Dystrophy
- ❑ Osteoporosis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Whiplash

Respiratory System
- ❑ Asthma
- ❑ Allergies
- ❑ Bronchitis
- ❑ Sinusitis
- ❑ Frequent Cold/ Flu

Circulatory System
- ❑ Atherosclerosis
- ❑ Thrombosis
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Stroke
- ❑ Varicose Veins
- ❑ Poor Circulation

Digestive System
- ❑ Recent change in appetite
- ❑ Acid Reflux
- ❑ Diarrhea
- ❑ Constipation
- ❑ Ulcers
- ❑ Food Allergies
- ❑ Gall Stones
- ❑ Hepatitis

Immune System
- ❑ Cancer
- ❑ Chronic Fatigue Syndrome
- ❑ Fibromyalgia
- ❑ Diabetes
- ❑ Edema
- ❑ HIV/AIDS
- ❑ Lupus
- ❑ Lymphoma

Nervous System
- ❑ Alzheimer's
- ❑ Headaches or Migraines
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Seizures
- ❑ Sleep Disorders
- ❑ Shingles
- ❑ Spinal Cord Injury

Integumentary System (Skin)
- ❑ Burns
- ❑ Dermatitis
- ❑ Eczema
- ❑ Fungal Infections
- ❑ Impetigo
- ❑ Scars
- ❑ Rash

Emotional System
- ❑ Depression
- ❑ Anxiety
- ❑ Grief
- ❑ Anger
- ❑ Joy

Female Reproductive System
- ❑ Irregular Menstruation
- ❑ Painful Menstruation
- ❑ Difficult Conception
- ❑ Miscarriage
- ❑ Endometriosis
- ❑ Menopause
- ❑ Hysterectomy

Urinary System
- ❑ Frequent Urination
- ❑ UTI
- ❑ Kidney Stones

Additional Health Concerns: _____

_____

_____

What seems to make you feel better? _____

What seems to make you feel worse? _____

Have you had any accidents, illnesses, injuries, surgeries, or traumas that have affected your health in such a manner that you've never been totally well since? ❑Yes ❑No
Please list with approximate date

_____

_____

_____

_____

Please list any medications, with dosages, that you are currently taking:

_____

_____

_____

_____

Please list any vitamins, minerals, and herbs, with dosages, that you are currently taking:

_____

_____

_____

_____

GYNECOLOGY

Age of first menses:_____ Date of last menstrual period: _____ Duration of flow : _____

Blood clots: yes /no when: _____ Length of cycle: _____

Color of menstrual blood: pale /bright red/ dark red/ brown/ other

Texture of menstrual blood: thick/ thin /watery/ normal

Pain: yes /no when: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant? Yes/No

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear: normal/ abnormal Date of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? Yes/ No Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____

Please read the following statements, initial, and sign below in agreement and for consent to treatment:

_____ Chantal Davis abides by the highest standards of safety for your ultimate wellbeing. I understand that every precaution shall be made in my best interest and that all information that I share in the treatment setting shall be confidential.

_____ In the event you are unable to make an appointment, 24 hours notice is respectfully requested, so that I can offer your appointment time to someone else and reschedule your appointment for anew time that is better for you. Late cancellations and missed appointments will be billed at a fee of $35.

_____ To allow all patrons and practitioners within the office the greatest sense of serenity, please turn off your cellular phone, or in the case of urgency, turn it to a non-audible mode.

_____ I hereby authorize Chantal Davis to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following: (1) the insertion of various styles of sterile, one-time use acupuncture needles into my body at various depths and locations; (2) massage of the acupoints or channels; (3) moxabustion, a heat treatment using the herb arthemesa vulgaris; (4) homecare suggestions such as dietary changes or supplements, Chinese Herbs, exercises, lifestyle recommendations, or referral to other specialists.

_____ I have been informed that I have a right to refuse any form of treatment. I understand the nature of the treatment and the risks and possible consequences involved with acupuncture. In each treatment session there are opportunities to ask questions pertaining to my treatment. I understand that there is always a possibility of unexpected complications and that no guarantee can be made concerning the results of the treatment.

All information is correct to the best of my knowledge and it is my responsibility to inform Chantal Davis of any changes during the course of my treatment.

_____ ____ _____

Signature of Patient (or Patient's Guardian) Date Date