

Abundant Life Acupuncture & Massage

To help us provide you with the best possible care, please fill out this form as accurately as you can. All the information provided here will be held in strictest confidence. Feel free to ask if you have any questions.

Name _____ Age _____ Today's Date _____

Mailing Address _____ City _____ Zip _____

Street Address _____ Email _____

Sex _____ Marital Status _____ Birthdate _____ Work phone () _____

Employer _____ Cell phone () _____

Occupation _____ Home phone () _____

Height _____ Weight _____ Referred by _____

Emergency Contact _____ Relationship & Phone _____

Have you received acupuncture therapy before? _____

Main Complaint

Please rate your current pain or discomfort on a scale of 1-10:

Very slight 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes it feel better? _____ Worse? _____

Who else have you seen for this condition? _____

Please sign here if I may contact them regarding your case _____

Medical History (include dates).

Major illnesses _____

Occupational stress (chemical, physical, psychological) _____

Please circle any that apply: tobacco coffee black tea green tea soft drinks alcohol recreational drugs

How many glasses of water do you drink daily? _____ 8 oz. glasses

Exercise (please describe) _____

Diet: A.M. _____ Noon _____ PM _____

Snacks:

Family Medical History (circle) Diabetes Cancer High Blood Pressure Depression/Mental Disorder
 Hysterectomy Asthma Heart Disease Stroke Prostate/Kidney Disorders Alcoholism/Addiction

Personal Medical History – indicate dates

_____ cancer _____ hepatitis _____ high blood pressure &/or cholesterol
 _____ heart disease _____ rheumatic fever _____ thyroid disease
 _____ diabetes _____ seizures _____ sexually transmitted disease
 _____ emotional disorder _____ other: _____

Surgeries (type and date):

Significant trauma (auto accidents, falls, natural disaster, etc.):

Significant dental work (type & date):

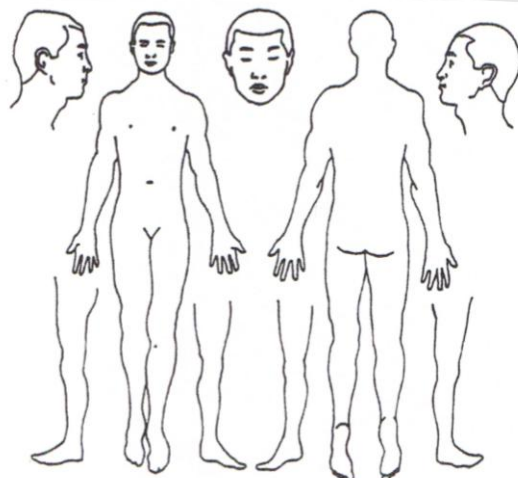
Allergies (drugs, chemicals, foods, & tests results):

Medications, vitamins, & herbs taken within the last 3 months---please include reason, date, & dosage:

Please tell us about the following areas of your life. Rank your feelings on a scale of 1 to 5 with 5 being the most favorable response:

	1	2	3	4	5	comments
Your relationship with your spouse or significant other						
your relationship with your family						
your diet						
your physical activity (exercise)						
your sexual relations						
your self image						
your job						

Indicate painful or distressed areas on figure(s):



Please check any of the following that recently/currently applies to you:

- | | | | |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Loose stools or diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Flatulence | <input type="checkbox"/> Belching | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prolapsed organ | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Feeling of retention of food in stomach | <input type="checkbox"/> Bloating | <input type="checkbox"/> HIV positive or AIDS | |
| <input type="checkbox"/> Tendency to become obsessive in your work or relationships | | | |

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Insomnia (what time?) _____ | <input type="checkbox"/> Heart palpitations/racing | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Dream-disturbed sleep/nightmares | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Anxiety (attacks) | <input type="checkbox"/> Easily startled |

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Headaches/migraines (describe location+ sensation) _____ | <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Spots before eyes/Night blindness | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Shoulder or neck tension | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Difficult bowel movements | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Impatience |
| <input type="checkbox"/> Depression/ Indecisiveness | <input type="checkbox"/> Fullness behind the ribs | <input type="checkbox"/> Soft or brittle nails | <input type="checkbox"/> Easily irritated |

- | | | | |
|--|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Weak voice | <input type="checkbox"/> Sadness/Grief |
| <input type="checkbox"/> Sinus congestion/infections | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Recent use of antibiotics | <input type="checkbox"/> Cough | <input type="checkbox"/> Sore throat | |
| <input type="checkbox"/> Nasal discharge: <input type="checkbox"/> Clear <input type="checkbox"/> White <input type="checkbox"/> Green <input type="checkbox"/> Bloody <input type="checkbox"/> Thick <input type="checkbox"/> Thin and watery | | | |

Skin problems: _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Low back pain/weakness | <input type="checkbox"/> Weak knees |
| <input type="checkbox"/> Edema or swelling | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Prostate disorders |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Urinary disorders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Teeth/gum problems | <input type="checkbox"/> Reduced sexual energy | <input type="checkbox"/> Fearfulness |

- | | | |
|--|--|---|
| <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> No energy to speak | <input type="checkbox"/> Lack of strength |
| <input type="checkbox"/> Dislike physical movement | <input type="checkbox"/> General physical weakness | <input type="checkbox"/> General fatigue |

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Dry, brittle hair | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Skin rashes | Numbness (where) _____ | |

- | | | |
|---|--|--|
| <input type="checkbox"/> Aversion to cold | <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Easily chilled |
| <input type="checkbox"/> Frequent clear urination | <input type="checkbox"/> Lack of thirst | <input type="checkbox"/> Desire for hot drinks |

- | | | |
|--|---|--|
| <input type="checkbox"/> Frequently thirsty | <input type="checkbox"/> Hot hands and feet | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Low-grade afternoon fever | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Red, flushed cheeks |

Other _____

Gynecological

Is there any possibility that you are pregnant? Yes No Birth control _____

Pregnancies _____ # Births _____ # Miscarriages _____ # Abortions _____ # Premature births _____

Menstrual flow: Heavy Light Clots Painful Color of menses: _____

No. of days between periods _____ Length of period _____

Date of last period _____ Date of last PAP _____ PAP results _____

Age at first menses _____ Spotting between periods _____ Vaginal sores _____

PMS: Breast soreness Bloating Moodiness Irritability Cramps Other _____

Perimenopausal: Skipped/irregular periods Hot flashes Moodiness Vaginal dryness

Menopause/age: _____ Hysterectomy/age and reason: _____

Vaginal discharge Breast lumps/cysts Endometriosis/When: _____ Other _____

Other

How would you describe your overall emotional state/tendency? _____

Please let us know if there are any other issues that you would like to discuss: _____

For Your Information---please read and sign.

- 1) Only sterile, disposable needles are used. Treatment procedures include: Acupuncture (insertion of needles), Cupping (cups place on skin with a vacuum effect), Gua Sha (rubbing an area with a blunt instrument), Moxa (burning of moxa herb to warm acupoint), Herbs (pill, powder, tincture, paste, plaster, raw for internal or external use), and Massage (Swedish, Shiatsu, Tuina, Reiki, Touch for Health, Pain Neutralization Technique).
- 2) Occasionally you may get temporary discoloration of the skin or a small hematoma (a little bruise) after an acupuncture needle is removed. This is not a cause for concern---it will go away after a few days. Gentle pressure applied to the site will stop any small amount of bleeding that is occurring under the skin. Potential risks (rare): nausea, loose bowel movements, abdominal cramping, pneumothorax, or slight aggravation of some symptoms existing prior to the acupuncture treatment before symptoms improve. After receiving an acupuncture treatment, you may feel a little light-headed. If so, please have a seat in the reception room or take a short walk around our building. In a few minutes, you will feel relaxed and clear-headed.
- 3) Herbal prescriptions and herbal patent medicines are intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.
- 4) Please do not wear cologne, perfume, or strongly scented lotion on the day of your appointment with us. Many of our clients are allergic or sensitive to them.
- 5) All fees for medical services are due at the time of each treatment unless other arrangements are made. If you need to cancel an appointment, please give 24 hours notice (48 would be kinder) to avoid being required to prepay for appointments.

Yes No - I have been evaluated by an MD/dentist within 12 months for the condition being treated. I understand Texas requires acupuncturists to recommend I see an MD/dentist for this condition.

Yes No - I have received a referral from my chiropractor within the last 30 days for acupuncture.

Yes No -After a chiropractor's referral, if no substantial improvement occurs after two months or 20 treatments, whichever comes first, I understand that the acupuncturist is required to refer me to a physician. It is my choice whether to follow this advice.

I have read the above information. I hereby request to be treated with acupuncture and/or Chinese herbal medicine for my condition. I hereby release Lea H. Siebert from any and all liability that may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name _____ Signature _____ Date _____

Parent Name _____ Signature _____ Date _____