deborah stotzky M.S., L.Ac

acupuncture treatment information form

all information provided on this form is confidential

name:_____date:___/___/___

email:_____

address:_____

telephone:cell:_____other:_____

age:_____date of birth:_____/_____/_____ occupation:_____ sex:__m__f

referred by_____have you received acupuncture before?_____

what would you like treated with acupuncture?_____

_____

what medical diagnosis have you received?_____

what other treatments have you received for this condition?_____

what medications are you taking?_____

for what conditions?_____

are you currently taking blood thinning medications?_____

past medical history

please check all conditions that apply currently or in the past:

__AIDS/HIV __alcoholism __asthma __cancer __diabetes __emphysema

__heart disease __hepatitis A / B / C __herpes __lyme disease

__multiple sclerosis __pacemaker __seizures __stroke __tuberculosis

__latex allergy __lymph nodes removed __other_____

please describe any significant injuries, surgeries or illness:_____

_____

are you currently pregnant?__yes___no are you currently trying to get pregnant?___yes___no

energy & exercise

how is your energy?_____do you fatigue easily?_____

what time of day is your energy highest?_____lowest?_____

what kind of exercise do you do?_____

emotions & sleep

how do you feel emotionally?_____

do you have: __panic attacks __depression __anxiety __bad temper __nervousness

__fear attacks __poor memory __difficult concentration __other_____

how do you feel about your relationship?_____your work?_____

how/where do you hold your stress?_____

how many hours do you generally sleep per night?_____

do you have difficulty with any/all of the following: __falling asleep __staying asleep

__dream disturbed sleep __waking _____times per night to urinate

diet & food

how is your appetite?_____

please list any food cravings:_____intolerances_____

please rate your taste preferences 1 to 5 (1 = like most 5 =like least)

____salty ____sour ____bitter ____sweet ____spicy

gastrointestinal

please check all that apply: __belching __nausea __vomiting __vomiting blood

__ulcers __bloating __acid regurgitation __heartburn __hernia __indigestion

__severe stomach pains __other_____

how often do you have a bowel movement?_____per day / per week (circle one)

please check all that apply: __constipation __diarrhea __gas __burning __hemorrhoids

__use laxatives __undigested food in stool __loose stool __hard/dry stool __itchiness

__blood in stool __painful bowel movement __other_____

cardiovascular

have you been diagnosed with heart trouble?_____

please check all that apply: __chest pain __palpitations __varicose veins __poor circulation

__high/low blood pressure __irregular heart beat __cold hands & feet

urinary

urination: how often?:____per day color: __clear __yellow __dark yellow/orange

please check all that apply: ___trouble starting stream __frequent urination __incontinence

__pain __burning __urinary tract infections __blood in urine __dribbling when sneezing

__kidney stones __other_____

women

at what age did you start menstruating? _____ # of days per cycle:_____

# of days of flow: _____ color: __bright red __red __deep red __brown

please check all that apply: __irregular menstruation __heavy flow __light flow __clots

__vaginal itching/burning __spotting between periods __discomfort/pain before period

__discomfort/pain during period __breast distention around cycle __yeast infection

any PMS symptoms?_____

any vaginal discharge?_____ color:_____

# of pregnancies:_____ # of deliveries:____

any menopausal symptoms?_____

men

please check all that apply: __prostatis __impotence __penis blood/mucous discharge

__other_____

respiratory, eyes, ears, nose, throat & head

do you smoke?_____ _____per day, for_____years

please check all that apply: __frequent colds __chronic runny nose

__chronic cough (dry / hacking) __cough blood __pain inhaling __shortness of breath on exertion __at rest __asthma __nose bleeds __painful/red eyes __poor vision

__see spots __dizziness __cold sores __bleeding gums __dry mouth

__frequent sore throat __ear pain __ringing in ears __popping ears

__frequent headaches migraines - describe:_____

skin & hair

please check all that apply: __dry skin __skin rashes __itching __acne __eczema __hives

__hair loss __premature graying __other_____

muscles, joints & bones

do you have (please circle): pain / tightness / stiffness where?_____

the pain is:: __sharp __aching __numb __deep pain __burning __dull

__tingling __pain worse/better with heat __pain worse/better with cold

__pain worse/better with pressure __pain worse am/pm __other_____

I have : please check all that apply: __swollen joints __arthritis/joint pain __tendinitis

__bone pain __rheumatism __mucle cramping __muscle pain __repetitive strain injury

family history

mother:_____

father:_____

siblings:_____

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acupuncture informed consent form

Please be advised that everyone responds differently to acupuncture treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until several days go by. Some people notice that their pain seems to be worse before it gets better. As a result of an acupuncture treatment, temporary mild pain or soreness, generalized fatigue, numbness, tingling or bruising can occur.

In addition, you are advised to consult a physician regarding the condition or conditions for which you are seeking acupuncture treatment. Clients are recommended to seek the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.

Thank you.

_____ _____

I have read & understand the above statement Date
Signature of Patient

_____

Signature of Witness

thank you

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CANCELLATION POLICY:

To cancel or reschedule an appointment I respectfully request that you notify me a minimum of **24 HOURS** prior to the appointment (48 hours is greatly appreciated!). Last minute cancellations, reschedules or no shows will be charged in full.

Please print name & date

_____

Please sign & date

_____