PATIENT INFORMATION

NAME: ______________________ DATE OF BIRTH: ______________________

ADDRESS: ______________________ CITY: ______________ STATE: ________ ZIP: ________

EMAIL: ______________________ PRIMARY PHONE: ______________________

EMERGENCY CONTACT: ______________________ EMERGENCY PHONE: ______________________

OCCUPATION: ____

HAVE YOU RECEIVED ACUPUNCTURE BEFORE? ❑YES ❑NO

WHO ARE YOUR CURRENT HEALTHCARE PROVIDERS?

____

____

____

HOW DID YOU HEAR ABOUT US?

❑ Friend or family ❑Health Practitioner ❑Picked up Postcard/Print Material ❑Google search ❑Yelp ❑Facebook/Instagram

❑ Other ______________________

PATIENT INFORMED CONSENT

I agree to receive acupuncture treatment by licensed acupuncturist Kimberly A Clements M.Ac. L.Ac. with Tend Acupuncture LLC. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and in rare cases, dizziness or fainting. On rare occasions, current symptoms may worsen before they find relief. I also understand there is always a possibility of unexpected complications and I understand that no guarantee can be made concerning the results of the treatment. I understand that Tend Acupuncture LLC uses only sterile, disposable, single-use needles, practices safe needling techniques, and maintains a clean and safe environment.

Medical Treatment — I recognize that my acupuncturist is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I am free to consult a medical doctor or any other licensed practitioner at any time, I understand also that if there is an emergency or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.
If I am pregnant or become pregnant, I will notify my practitioner immediately.

Client Responsibilities — I understand that it is my responsibility as a dient to inform my practitioner about all aspects of my health and that, as service progresses, to inform my practitioner of changes that occur. If I experience any pain, discomfort, or adverse side effects, it is my responsibility to immediately notify my practitioner. Additionally, if I currently have any infectious disease (cold, flu, intestinal virus etc.) or rash that I am aware of, I am to notify the practice prior to my appointment.

I have read this form and have also had an opportunity to ask questions about its content. I intend this consent form to cover the
entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I AGREE:

SIGNATURE: ______________________________ DATE: ______________

PRINT NAME: ______________________________

CANCELLATION POLICY

I understand that Tend Acupuncture will charge the full session fee when a session is broken either by not providing 24 hours notice of cancellation, not showing, or showing up 20-25 minutes after my appointment time.

SIGNATURE: ______________________________ DATE: ______________

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TEMPERATURE
How warm or cold you feel relative to others
(e.g., do you usually need to wear more layers or fewer)?

COLD |——|——| HOT

- ❑ Cold hands or feet
- ❑ Cold "in the bones"
- ❑ Hot flashes
- ❑ Night sweats
- ❑ Chills
- ❑ Numbness
- ❑ Hot at night
- ❑ Unusual sweats: *specify when & where on body:*

____

ENERGY

LOW |——|——| HIGH

- ❑ Sudden energy drop: *time of day* ____________
- ❑ Energy drop after eating
- ❑ Shortness of breath
- ❑ Heart palpitations
- ❑ Blood pressure high/low
- ❑ Fatigue
- ❑ Dependence on caffeine/stimulants
- ❑ Wired or ungrounded feeling
- ❑ Body or limbs feel heavy
- ❑ Body or limbs feel weak
- ❑ Bleed/bruise easily
- ❑ Difficulty concentrating
- ❑ Poor memory
- ❑ Dizziness/lightheadedness
- ❑ Headaches: ____ *x per week*

DIGESTION

DIARRHEA |——|——| CONSTIPATION

- ❑ Indigestion
- ❑ Gas
- ❑ Bloating
- ❑ Belching
- ❑ Poor appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Bad breath
- ❑ Heartburn
- ❑ Hernia
- ❑ Hemorrhoids
- ❑ BM: How often? ____ *x per* ____ *days*

Stools keep shape? ❑*YES* ❑*NO*

- ❑ Alternating diarrhea & constipation/IBS
- ❑ Dry stools
- ❑ Difficult to pass
- ❑ Tired after BM
- ❑ Excessive hunger
- ❑ Pain with BM
- ❑ Foul-smelling stools

EMOTIONS
What emotions are troubling to you or dominate your experience?

- ❑ Anger
- ❑ Irritability
- ❑ Anxiety
- ❑ Worry
- ❑ Obsessive Thinking
- ❑ Sadness
- ❑ Grief
- ❑ Depression
- ❑ Joy
- ❑ Fear
- ❑ Timidness / Shyness
- ❑ Indecisiveness

SLEEP

- ❑ ____ *# hours per night*
- ❑ Difficulty falling asleep
- ❑ Disturbing dreams
- ❑ Restless sleep
- ❑ Not rested upon waking
- ❑ Wake ____ *x per night* *at* *am / pm*
- ❑ Wake to urinate: *how often:* ____

WOMEN

- ❑ Age at first menses: ____
- ❑ Average length of full cycle: ____ days (i.e. 28)
- ❑ Average length of menses: ____ days (i.e. 3-4)
- ❑ Last menses start date:

# of pregnancies: ____ # of births: ____
premature: ____ # of abortions: ____
of miscarriages: ____

Do you take hormonal birth control pills? ❑*YES* ❑*NO*

Have you seen any specialists to assist in getting pregnant? ❑*YES* ❑*NO*

If so what assisted interventions have you tried?
(e.g., IUI, IVF, etc) ______________________________

PERIODS
- ❑ Heavy
- ❑ Light
- ❑ Painful
- ❑ Irregular
- ❑ Clots
- ❑ Changes in body/psyche prior to menstruation
- ❑ Fatigue
- ❑ Breast tenderness
- ❑ Mood changes
- ❑ Digestive changes
- ❑ Mid-cycle spotting

CRAMPS
- ❑ Before bleeding
- ❑ First day
- ❑ During period

MENOPAUSE
- ❑ Age at last menses: ____
  Year changes began: ____
- ❑ Vaginal dryness
- ❑ Loss of sex drive
- ❑ Hot flashes: ___x per day
- ❑ Night sweats: ___x per week

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PRIMARY CONCERNS OR GOALS

Please list your top three concerns/goals in order of importance to you.

		When did this start?	*What makes it better?*	*What makes it worse?*
1.	1 — 10			
2.	1 — 10			
3.	1 — 10			

HEALTH HISTORY

Check the "Self" box if you have or had the condition and the year it began. Check the "Family" box if there is a family history.

Condition	Self | Year	Family
❑ Cancer ____________	❑	❑
❑ Diabetes	❑	❑
❑ Hepatitis	❑	❑
❑ High Blood Pressure	❑	❑
❑ Heart Disease	❑	❑
❑ Stroke	❑	❑
❑ Seizure Disorder	❑	❑
❑ Thyroid Disease	❑	❑
❑ Asthma	❑	❑
❑ Eating Disorder	❑	❑

Condition	Self | Year	Family
❑ Osteoporosis	❑	❑
❑ STD ____________	❑	❑
❑ Rheumatic Fever	❑	❑
❑ Substance Dependency	❑	❑
❑ Allergies ____________	❑	❑
❑ Psychological ____________	❑	❑
❑ Kidney Disease	❑	❑
❑ Anemia	❑	❑
❑ History of Trauma	❑	❑

INJURIES & SURGERIES

Please list what happened to what body area and when it occurred. Include dental.

Condition	Issue

MEDICATIONS

Please list any medications, herbs or supplements that you take on a regular basis.

Supplement	Condition