Patrick Yoerger L.Ac. - Acupuncture/Tui Na Intake - Confidential Information

Welcome! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name _____Date of birth_____/_____/_____

Address_____

City_____State_____Home Phone_____

Work Phone_____Occupation_____

Email:_____Would you like to be on our email list___Yes ___No

Have you ever received Acupuncture/ Tui Na? ____Yes ____No

Are you currently seeing a healthcare professional? ____Yes ____No

If yes, please list reason for treatment_____

Please review this list and check the conditions that have affected your health either recently or in the past.

___arthritis
___depression, panic disorder, anxiety
___diabetes
___blood clots
___broken/dislocated bones
___bruise easily
___cancer
___chronic pain
___constipation/diarrhea
___auto-immune condition*
___hepatitis (A, B, C, other)
___skin conditions
___stroke
___surgery
___TMJ disorder
___bleeding disorder
___pacemaker
___diverticulitis
___headaches
___heart conditions
___back problems
___high blood pressure
___insomnia
___muscle strain/sprain
___pregnancy
___scoliosis
___seizures
___whiplash
___chemical dependency (alcohol, drugs)

(*AIDS, chronic fatigue, fibromyalgia, lupus ,etc.)

Do you have any reason to believe you may be pregnant? Y N

If yes, how far along are you?

_____

If any of the above needs to be detailed or if there is anything else to share, please do so:

_____
_____
_____

Do you have any of the following today: ____skin rash ____cold/flu ____open cuts

____severe pain ____contagious disease ____ injuries/bruises

Do you have any allergies or sensitivities to:

____medications _____foods (dairy, gluten, nuts, etc.)

____environmental allergens (dust, pollen, fragrances) ____skin care products

If any of the above are checked, please give details: _____

Are you wearing: ____contact lenses ____hearing aid ____hairpiece

What are your goals/expectations for this therapy session? _____

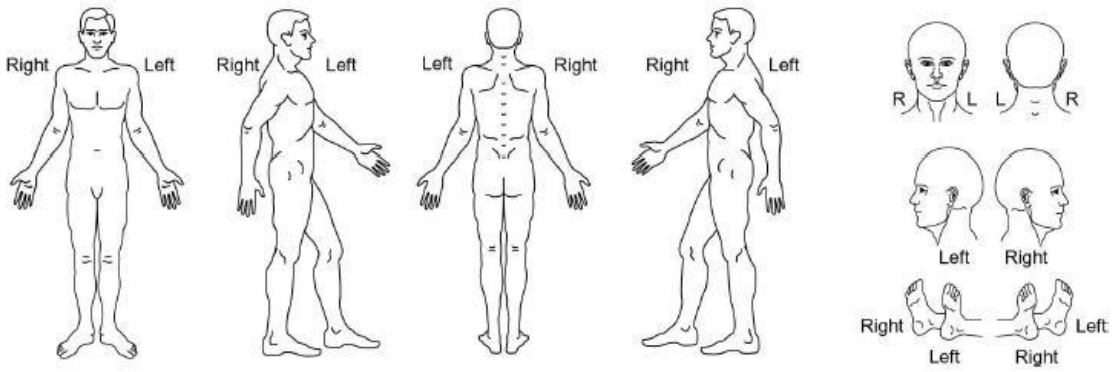
Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain

Mid Back Pain Low Back Pain Leg Pain Sciatica Joint Pain

Please indicate below areas where you experience: pain: x x x x pins and needles: 0 0 0 0

numbness: = = = =



The following sometimes occur during an acupuncture treatment and are normal responses to relaxation, they may occur during the treatment or in the hours or days following treatment: sighing, yawning, changes in breathing, stomach gurgling, emotional feelings and/or expression, movement of intestinal gas, falling asleep, memories.

Signature:_____ Date_____/_____/_____