



STILLPOINT ACUPUNCTURE

Transforming lives through the power of Chinese medicine

New Patient Intake

Name: _____ Date of Birth: _____ Today's Date: _____

Please list the main reason you are here today:	
On a scale of 1-10 (1 = not at all, 10 = severely), how does this complaint interfere with your daily life?	
What seems to help?	What seems to make it worse?
What other therapies have you tried for this complaint?	
Name(s) of any physician or health care practitioner you see or have seen within the past year:	
List all medications, herbs or supplements that you take on a regular basis (use back if necessary):	
List any allergies you have to medications, herbs, or foods:	
List past surgeries and/or hospitalizations:	
Do you have a pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any metal plates or screws in your body? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?
Do you think you might be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	
Are you currently trying to conceive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not trying, but also not using birth control	
If using birth control, what type?	

Family Medical History (please indicate any illnesses in immediate family – parents, children, uncles, aunts, siblings, grandparents)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies/Autoimmune | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Heart attack/Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Headaches / Migraine | <input type="checkbox"/> Neurological (Dementia, Parkinson's, MS, etc.) | |

Is there anything else we should know about your family? _____

Your Past Medical History (please indicate any conditions you have now, you have had in the past, or think might be important)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney or gallstones | <input type="checkbox"/> Sexual/Physical/Emotional Abuse or Rape |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tick-related disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Trauma (fall, car accident): _____ |
| <input type="checkbox"/> Birth trauma (yours) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> PTSD | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers/GERD/Acid Reflux |
| <input type="checkbox"/> Childhood illness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | |

Is there anything else we should know about your medical history? _____

FOR OFFICE USE ONLY	
Initial Diagnosis:	Goal of Treatment Course:
Expected Course of Treatment:	Date of Next Review:
Plan includes Chinese Herbs?	Practitioner Initials?



Symptom Checklist

Name: _____ Date: _____

Please check any of the following symptoms you experience frequently or have a tendency toward

<input type="checkbox"/> Fatigue/ Low Energy <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Tired After Eating <input type="checkbox"/> Low Appetite <input type="checkbox"/> Strong Appetite <input type="checkbox"/> Loose Stools <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal Bloating <input type="checkbox"/> Heartburn / Reflux <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Frequent Hiccups or Belching <input type="checkbox"/> Flatulence <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Bad Breath <input type="checkbox"/> Excessive Vaginal Discharge <input type="checkbox"/> Tendency To Worry / Obsess	<input type="checkbox"/> Frequent Irritability / Frustration <input type="checkbox"/> Depression Tendency to Feel Stressed <input type="checkbox"/> Frequent Sighing <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Pain In Neck and Shoulders <input type="checkbox"/> Headaches <input type="checkbox"/> Pain Under Ribcage <input type="checkbox"/> Floaters <input type="checkbox"/> Can't See Well at Night <input type="checkbox"/> Red Eyes <input type="checkbox"/> Wake Between 1-3am <input type="checkbox"/> Trouble Falling Asleep <input type="checkbox"/> Dizziness <input type="checkbox"/> Tight Muscles <input type="checkbox"/> Painful Periods <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Inability to Cry
<input type="checkbox"/> Recurrent Colds / Infections <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Allergies <input type="checkbox"/> Sweat Easily <input type="checkbox"/> Do Not Sweat <input type="checkbox"/> Blood Or Mucus in Stool <input type="checkbox"/> Pain In Teeth / Gums <input type="checkbox"/> Skin Problems <input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> People Ask You To Speak Up Often <input type="checkbox"/> Feel Sad	<input type="checkbox"/> Low Back Pain <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Knee Pain <input type="checkbox"/> Low Sex Drive <input type="checkbox"/> High Sex Drive <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Night Sweats <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Poor Hearing <input type="checkbox"/> Ringing in Ear <input type="checkbox"/> Wear Socks To Bed <input type="checkbox"/> Congenital Abnormalities <input type="checkbox"/> Vaginal Dryness
<input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory Problems <input type="checkbox"/> Sores on Tongue <input type="checkbox"/> Startle Easily <input type="checkbox"/> Laugh Inappropriately	Other Symptoms Not Listed Here:
For Practitioner Use Only	



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Consent for Treatment

Name: _____ Phone: (H) _____ (C) _____

Street: _____ City: _____ State: _____ Zip: _____

Email: _____ Referred by: _____

Gender: _____ Age: _____ Ht: _____ Wt: _____ Birthdate: _____ Occupation: _____

Employer Name/Address: _____

Personal Physician: _____ Date of last physical exam: _____

Emergency contact: _____ Phone: _____

Phone number(s) preference for scheduling and other questions: _____

I, the undersigned, hereby consent to receive acupuncture treatment from the licensed practitioners of Stillpoint Acupuncture.

I am fully aware that the acupuncture needles are sterile and disposable and that no needle used to treat me has ever been used on another person.

I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that complications may result from acupuncture treatment. Among these possible complications are: bruising, fainting, numbness, weakness, nausea, hematoma, infection, burns, pain and discomfort, pneumothorax, and aggravation of present symptoms.

I understand that acupuncture and Chinese medicine is not a substitute for standard Western medicine, that certain health disorders may require allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of or concurrently with acupuncture treatment.

I fully realize that I may withdraw from my treatment at any time.

I understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management of this clinic, in the event of accidental injury on these premises.

Name (please print): _____

Signature: _____ Date: _____

Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the above terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Parent/Guardian Signature: _____ Date: _____

Stillpoint Acupuncture embraces equality, diversity and inclusion as crucial elements of healthy people and healthy communities.



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Privacy Notice

At Stillpoint Acupuncture, we make every effort to keep your personal and medical information confidential. The following explains what we do with the information we ask you to provide:

Your name and contact information are seen by your practitioner and our bookkeeper who enters you into our database.

Your medical information is kept in a file and is accessed only by the practitioners in order to make medical decisions and to document your treatments. Your file may also be seen by our staff in order to a) file the chart, b) contact you regarding scheduling, or c) to prepare an herbal formula the practitioner has prescribed.

Every person who comes in contact with your chart has signed a confidentiality agreement. A copy of this agreement can be made available to you upon request.

We may periodically access your chart in order to conduct research that helps us improve our care. For example, we may look at all the charts of people with back pain, in order to determine how often those treatments are effective.

We will not provide information from your chart to anyone outside our office unless that is specifically requested by you in writing.

We will not discuss your case with anyone else unless you specifically give us permission to do so. This includes your family members and other medical providers.

Special note to participants in the acupuncture clinic:

As you know, the clinic setting is less private than our office setting. In order to protect your privacy here, we use check in forms for expressing to your practitioner anything you may not want to be overheard.

I have read this document and agree with its terms.

Signed: _____ Date: _____

Would you like a copy of this agreement? Yes No



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Cancellation Policy

- Please help keep our practice working well for everyone by giving 24-hours' notice if you must cancel.
- In the event that you miss your appointment or cancel with less than 24-hours' notice, you will be charged for the missed appointment.
- We understand that urgent situations arise and urge you to call the office to discuss cancellations caused by illness, injury or other emergency.
- You will often receive a reminder call 48 hours before your appointment. These calls are a courtesy, and not guaranteed. Not receiving a reminder call does not excuse a missed appointment.

I have read the above and agree to terms_____. (Please initial)



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Special Consent for Community Clinic

Name: _____ D.O.B: _____ Today's Date: _____

- I understand that the Stillpoint Acupuncture Clinic is designed to provide lower cost acupuncture in a group setting. These treatments are designed primarily to reduce stress and to alleviate physical and emotional pain. While I may experience significant benefit from the acupuncture I receive here, I do not expect the acupuncturists in the Clinic to be able to comprehensively manage all of my health concerns.
- I understand that if I would like more comprehensive treatment of my health, I am free to make a private appointment at Stillpoint Acupuncture (or any other health care office) and pay the regular fees associated with that appointment.
- I understand that because treatments in this clinic are provided in a group setting, there is a possibility that my conversations may be overheard, and I will not hold Stillpoint acupuncture responsible for any breach of confidentiality that occurs because I am talking about personal issues while other people are present in the room. I understand that pen and paper will be provided for me if I wish to communicate something privately to my practitioner.
- I agree not to repeat the private conversations of others that I may inadvertently overhear as a participant in this Clinic.

I understand that the treating practitioner in the Community Clinic may change without notice.

I have read the above and agree to terms _____. (Please initial)