Acupuncture with Melissa

Health Intake Form

This is a confidential questionnaire to help us determine the best coarse of treatment for you.
If you have any questions please ask.

Personal information

Date:_____

Name:_____ D.O.B:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Occupation:_____ Emergency contact:_____

_____

How did you hear about us:_____

Medical history

Are you under the care of a physician for any medical condition? (If yes please explain):_____

Are you currently taking any medication (please list):_____

Please check any of the following conditions that apply:

__Headaches/Migraines	__Asthma	__Hypertension
__Allergies	__Cancer	__TMJ syndrome
__Depression	__Scoliosis	__Carpal tunnel
__Diabetes	__Menopause	__Fibromyalgia
__Epilepsy/Seizures	__Neurological conditions	
__Digestive problems	__Eating disorders	__Heart disease
__Skin conditions	__Osteoporosis	__Varicose veins
__Arthritis	__Anxiety	__Broken bones
__Tumors	__Blood clots	__Lymph nodes removed
__Aneurysm	__taking blood thinners	__have a pacemaker

List surgeries and dates (within five years):_____

Any other conditions or comments?:_____
_____

Any chronic or frequent pain? Please explain:_____

For Women

Are you Pregnant? □ Yes □ No
# of pregnancies_____

# of days between period_____ # of days of flow_____
color of flow_____ clots □ Yes □ No Color_____
Have you been diagnosed with:
□Fibroids □ endometriosis □ ovarian cysts
Average # of pads used per day 1st_____ 2nd _____3rd _____ 4th _____5th _____
+ days_____
Pain □before □ during □ after period. Location of pain □ lower back □ thighs □ lower abdomen □ other
Type of pain:
□cramping □stabbing □burning □aching □dull □bloating □consistent □intermittent
other symptoms related to menses:

□ discharge	□ vaginal dryness	□ headache	□ nausea
□ constipation	□ diarrhea	□mood swings	□ excessive appetite
□ lack of appetite	□ night sweats	□increased libido	□decreased libido
□ insomnia			

For Men

Frequency of urination_____ daytime _____nighttime. Color of Urine □clear □ murky □ Oder

Symptoms related to prostate:

□ Delayed stream	□ dribbling	□incontinence	□urine retention
□rectal dysfunction	□increased libido	□decreased libido	□premature ejaculation
□Impotence	□back pain	□ groin pain	

For everyone
Symptoms

Please indicate if you have any of the following symptoms with __ never ✔ sometimes ✖frequently

__lack of appetite
__excessive appetite
__loose stools or diarrhea
__indigestion
__vomiting
__belching, burping
__heartburn, reflux
__feeling of retention of food in stomach
__tendency to become obsessive at work, relationships etc.

__insomnia, difficulty sleeping
__heart palpitations
__cold hands feet
__nightmares
__mentally restless
__laughing for no apparent reason
__angina pains
__abdominal pains
__chest pain
__sciatic pain
__headaches
__pain or coldness in the genital area

__cough
__shortness of breath
__decreased sense of smell
__nasal problems
__skin problems
__feeling of claustrophobia
__bronchitis
__constipation
__hemorrhoids
__recent use of antibiotic

__eye problems
__jaundice(yellowing of skin or eyes)
__difficulty digesting oily foods
__gall stones
__light colored stool
__soft or brittle nails
__easily angered or frustrated
__difficulty in making decisions or plans
__lack of flexibility in muscles/ spasms

__low back pain
__knee problems
__hearing impairment
__ear ringing □high pitch □ low pitch
__kidney stones
__decreased sex drive
__hair loss
__urinary problems
__fatigue
__edema
__blood in stool
__black tarry stool
__easily bruised
__difficulty to stop bleeding
__tendency to catch colds
__intolerance to weather changes
__allergies
__hay fever
__dizziness
__tendency to faint easily
sudden weight loss

How do you feel about the following areas of your life?
Check appropriate box

	Great	Good	Fair	Poor	bad
Energy					
Diet					
Sex					
Self					
Work					
Exercise					
spirituality					

Soap Notes

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213 Route 37 E.
Toms River, NJ 08753
732-664-9220

Acupuncture Informed Consent for Treatment

I _____ the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, guasha, bleeding therapy, shiatsu, electro acupuncture, medical massage, and dietary advice based on Chinese medical theory.

You will be treated with the insertion of sterile, one time use disposable needles. After the needles are placed it is best not to change positions or move without assistance. Communicate freely to your acupuncturist if you are uncomfortable for any reason during your treatment.

I understand that while acupuncture is generally a safe method of treatment, certain adverse effects may result from treatment. These may be, but are not limited to fainting, some local bruising, puffiness, redness, blood, and temporary pain or discomfort at the site of the needles during or after the treatment.

Some of the potential benefits include drugless relief of presenting symptoms, improved general health, elimination of the presenting problem, reduction of pain and associated symptoms.

With this knowledge you voluntarily consent to the above procedures and are aware of the possible risks involved. You have the opportunity to discuss the consent with your acupuncturist at any time. There is no guarantee of success or effectiveness of a specific treatment or series of treatments. It is recommended that your physician be consulted for any medical concerns prior to receiving acupuncture. Your acupuncturist cannot provide a Western medical diagnosis. If you think you may have a serious health condition, you are encouraged to seek the care of your physician.

I, the patient, hereby release the clinic from any and all liability, which may occur with the above-mentioned procedures. My signature indicates that I have read and understand this consent carefully, having provided correct information about ALL of my known medical conditions to the best of my knowledge, asked any questions and have received satisfactory answers

Patient signature Date

M. Melissa Campbell, L.Ac., Dipl. Ac., LMT Date

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Financial and Cancellation Policies

Dear Patient:

Thank you for choosing acupuncture to help your reach your health and wellness goals. The following is our cancellation and financial policy. Our main concern is that you receive optimal care resulting in better health. Therefore, if you have any questions or concerns about our policies, please do not hesitate to ask.

Payment for service is due at the time of service. Cash, check and credit are accepted for payment. We will be accepting insurance in the near future but for now we are able to give you a Super Bill to submit to your insurance company for reimbursement.

If you need to cancel your appointment, we kindly ask that you give 24 hours notice. Of course, life is unpredictable at times and there will be exceptions. However, if you miss an appointment and do not cancel there will be a $20 cancellation fee, which will be due at your next visit. We apologize for any inconvenience but this policy is made so other patients may benefit from your time slot if you should cancel. We appreciate your dedication to your health and the opportunity to serve you. Thank you for understanding.

Warm Regards,

M. Melissa Campbell, L.Ac., Dipl. Ac., LMT

Patient Signature