Appointment Date

General Information

Name_____
Address_____
Married □ Single □ Partner □ Divorced □ Widowed □
Date of Birth_____ Mobile Phone_____
Email Address_____ Occupation_____
Emergency Contact & Phone Number_____
Have you ever used acupuncture or traditional Chinese medicine? Yes No

Focus

What is your primary reason for seeking care at our office?
_____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?
□ work □ standing □ sexually □ sleep □ walking □ sitting
□ emotionally □ recreation □ bending □ socially □ relationships

What have you done about this? _____

Are you interested in: □ pain relief □ performance care □ maintenance care
□ preventive care □ holistic health □ stress relief □ nutrition □ herbal therapy

What are your health goals? _____
_____

List any past surgeries and when they took place:

_____
_____
_____

List any significant trauma and when it occurred (ie. car accident, falls, emotional, sexual, etc.):

_____
_____

List exercise and sport activities you have been or are currently involved in:

_____
_____

Female Concerns

Date of last menstruation: _____ Is your cycle regular? Yes No

Is your cycle painful? Yes No Have you ever been pregnant? Yes No

Birth Control? Yes No How long? _____

□ PMS □ Clotting □ Vaginal sores □ Vaginal pain □ Discharge

Medical History

Do you have any allergies? Yes No If so, what?

_____

Do you take any prescription medications? Yes No Please list ALL

_____
_____

Do you take any supplements? Yes No Please list ALL

_____
_____

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When?

Do you have a low point during the day? Yes No When?

What are your indulgences? _____

What are your hobbies / interests? _____

Web of Wellness

Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being. For each of the factors listed, please circle your overall level of satisfaction. 1 = not happy 10 = extremely happy

Family Health 1 2 3 4 5 6 7 8 9 10
Social Health 1 2 3 4 5 6 7 8 9 10
Mental Health 1 2 3 4 5 6 7 8 9 10
Financial Health 1 2 3 4 5 6 7 8 9 10
Career Health 1 2 3 4 5 6 7 8 9 10
Sexual Health 1 2 3 4 5 6 7 8 9 10
Physical Health 1 2 3 4 5 6 7 8 9 10
Spiritual Health 1 2 3 4 5 6 7 8 9 10

Signs / Symptoms - Please check all symptoms that pertain to you at the current time

□ cough □ allergies □ asthma □ grief / sadness □ chills / fever □ sore throat
□ sinus congestion □ constipation □ stiff neck / shoulders □ difficulty breathing
□ frequent colds □ skin rashes □ spontaneous sweating □ shortness of breath

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□ palpitations □ anxiety □ anemia □ dream-disturbed sleep □ poor memory □ fatigue
□ heart problems □ tongue ulcers □ restlessness □ insomnia □ easily startled
□ hot flashes □ speech problems □ chest pain

□ anger / irritability □ depression □ brittle nails □ vision problems □ joint pain
□ headaches □ muscle tension □ menstrual issues □ tinnitus □ muscle spasms
□ dizziness □ spots on eyes □ numbness / tingling

□ infertility □ dental problems □ hair loss □ impotence □ adrenal weakness
□ hearing problems □ incontinence □ fear □ urinary problems □ weak / brittle bones
□ cold hands / feet □ low back pain □ night sweats □ hot flashes □ aversion to cold

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□ edema □ digestive problems □ fatigue □ diarrhea □ acid reflux □ mental fogginess
□ organ prolapse (previously diagnosed) □ poor appetite □ loose stools □ bloating
□ petechiae / bruising □ heavy limbs □ bad breath □ hemorrhoids □ worry □ nausea

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□ low sex drive □ normal sex drive □ high sex drive

Urine is: □ normal color □ dark yellow □ cloudy □ clear □ reddish □ scanty □ painful
□ odorous □ burning sensation □ difficult □ painful □ urgent

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive medical system to help millions of people get well and stay healthy.

When a patient seeks acupuncture care and is accepted as a patient for such care, it is essential for both patient and acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health conditions(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of qi.

The ONLY practice objective is to detect and correct imbalances within meridian channels using acupuncture and TCM techniques.

Patients will be advised if a non-acupuncture related or otherwise unusual finding is encountered during the course of an acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

Before leaving today, you will be provided with an estimated treatment plan. As each patient is treated differently, according to their TCM diagnosis, these treatment plans are customized and no two will be the same.

I, _____ have read and fully understand the above statements. Therefore, I accept acupuncture care under these terms.

_____ _____

Signature Date

Intake Questionnaire

1. Primary Complaint (what do you want to focus on)?

_____

2. If there is pain associated with this problem, what is your pain level on a scale of 1 to 10, with 10 being the worst? _____

3. Body Temperature: Do you normally run hot or cold? Do you feel like you're taking clothing off or putting it on? Do you experience night sweats or spontaneous sweating?

_____

4. Vision: Do you have any issues with vision (ie. floaters, auras, etc.)? If you wear glasses or contact lenses, are you near-sighted, far-sighted, bifocals, reading only?

_____

5 Hearing: Do you have any issues with hearing (buzzing, ringing, which ear)? Please describe.

_____

6. Describe your daily diet for me: Do you eat 3 or more meals per day? Do you eat breakfast regularly? Do you eat lots of fruits and vegetables? Are you a vegan or vegetarian? Do you fast regularly? What kinds of meat do you eat and how frequently? Do you eat a lot of fast food / processed foods? How much water do you drink daily? Do you drink coffee, tea or soda? If so, how much per day? Do you crave certain foods on a regular basis (ie. salty, sweet, etc.)?

_____

_____

_____

_____

_____

_____

7. How often do you have a bowel movement? Do you lean towards constipation or diarrhea at all? Is there any blood or mucus in the stools? Are the stools difficult to pass? Are the stools loose or watery?

_____

_____

8. Do you wake up at night to urinate? If so, how often? Any issues with urinary tract infections? Any history of urinary or kidney stones?

_____

9. Describe your sleep. Approximately how many hours of sleep per night on average? Is your sleep restless? Do you dream? Do you have nightmares or night terrors? Do you wake up feeling rested or fatigued?

_____

_____

10. Are there any issues in your chest area: Palpitations? Chest pain? Do you have a pacemaker?

_____

11. Do you have bloating of gassiness on a regular basis? If so, is it food dependent?

_____

_____

12. Do you suffer from any type of autoimmune disease (ie. Crohn's, IBD, fibromyalgia, diabetes, eczema, etc.)? If so, how long ago were you diagnosed?

_____

_____

13. Do you suffer from any type of sexual dysfunction or sexually transmitted diseases? Is your libido normal?

_____

14. Tell me about your emotional health: Do you cry a lot? Sigh a lot? Get angry frequently? Depression? Anxiety? Stress? How do you deal with your emotions?

_____

_____

15. Does your primary complaint limit you in any way and if so, how?

_____

_____

16. Do you smoke? If so, how much per day / week? _____

17. Do you drink? If so, how much per day / week? _____

18. Are there any additional complaints or areas you would like to work on?

_____

_____

_____

Three Moons Acupuncture
Informed Consent Form &
Health Questionnaire

Patient Name: _____ DOB: _____

Due to recent health concerns, ALL patients must answer these questions and return the completed form to Three Moons Acupuncture prior to their scheduled appointment. Failure to do so, will result in cancelled appointments. This is being done to protect everybody and every patient is required to complete this form.

Please answer the following questions, then sign and date at the bottom.

1. Have you been in contact with anybody who has been known to have influenza, the common cold, COVID-19, SARS or any other contagious respiratory infection within the last 14 days?
   □ Yes If yes, please clarify_____

   □ No

2. Do you still have your sense of smell / taste? □ Yes □ No

3. In the last 14 days, have you experienced any fever, even low-grade? □ Yes □ No

4. In the last 14 days, have you experienced a sore throat? □ Yes □ No

5. In the last 14 days, have you experienced fatigue and / or body aches? □ Yes □ No

6. In the last 14 days, have you experienced any coughing or sneezing? □ Yes □ No

7. In the last 14 days, have you experienced any digestive upset (nausea, diarrhea, vomiting)?
   □ Yes □ No

I attest that the information provided is correct, to the best of my knowledge. I acknowledge any potential health risks and I do not hold Three Moons Acupuncture, LLC or Kimberly M. Filkins, L.Ac. liable in any way.

Signature: _____ Date: _____

Please return via email to kim@threemoonsacupuncture at least 12 hours before your scheduled appointment. If you have any difficulty, please call or text (262)977-8793.

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