chopstix LLC
acupuncture and bodywork

acupuncture new patient form

206-547-1104
4333 fremont
ave north
seattle wa 98103

Date: ___/____/___

Name: _____ Age: _____ Date of Birth: ___/____/___

Address: _____

City, State, Zip: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

SSN#: _____ Email Address: _____ Occupation: _____

Gender: M F Height/Weight: _____

Emergency Contact: _____ Phone: ( ) _____-_____

Referred by: _____

1. Are you new to acupuncture? Y N
2. Have you ever tried Chinese herbal medicine? Y N
3. Are you interested in Chinese herbal medicine options for your condition? Y N
4. What is the reason for your visit? Please describe your condition at it's worst.

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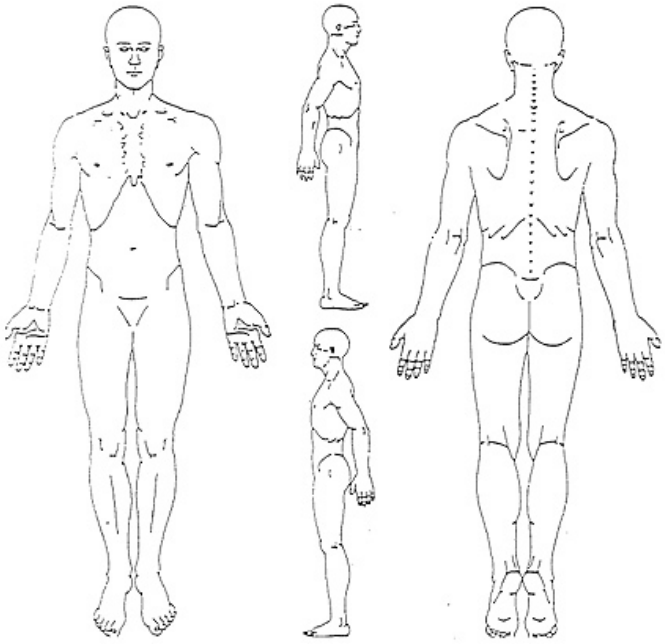
5. Circle the areas of pain or discomfort:



Frequency of complaint:
- O 100% of the time
- O 75% of the time
- O 50% of the time
- O 25% of the time

Intensity of the complaint:
- O Annoyance but no effect on activity
- O Tolerable with some impairment to activity
- O Tolerable with marked impairment to activity
- O Intolerable and can not perform any activities

How long has this condition bothered you?
_____

What seemed to be the initial cause? _____
_____
_____

Is it getting worse? Y N

Does it affect other areas of your body? Y N If yes, please explain:_____
_____

6. Does the condition interfere with your O work O sleep O other (please describe) _____
_____

7. If you went without treatment, how would it affect your quality of life? _____
_____

8. What seems to make the condition:

Better: _____

Worse: _____

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9. What, if anything, have you tried to treat the condition? _____

_____

10. If you are currently under the care of a health care practitioner for any condition/injury, please provide:

Practitioner Name:_____

Phone: ( ) _____ - _____

Description: _____

11. Please list any concurrent therapies: _____

12. Insurance Information ○ private ○ group ○ automobile ○ worker's comp

Insurance Company Name: _____

Address: _____

Phone: ( ) _____ - _____

Claim/Policy/ID#: _____

13. Medicare Information (if applicable):

Insurance Company Name: _____

Address: _____

Phone: ( ) _____ - _____

Claim/Policy/ID#: _____

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14. Family History: Please provide as much information as you can.

Allergies	
Aterliosclerosis	
Asthma	
Alcoholism	
Cancer	
Diabetes (type)	
Heart Disease	
High Blood Pressure	
Seizures	
Stroke	

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15. Your Medical History

Now	Past		Now	Past		Now	Past	
O		AIDs/HIV	O	O	Gout	O	O	Scarlet Fever
O	O	Alcoholism	O	O	Heart Disease	O	O	Seizures
O	O	Allergies	O	O	Hepatitus	O	O	Stroke
O	O	Appendicities	O		Herpes	O	O	Surgery (list)
O	O	Ateriosclerosis	O	O	High Blood Pressure	O	O	Thyroid Disorders
O	O	Asthma	O	O	Measles	O	O	Major Trauma (list)
O	O	Birth Trama (own)	O	O	Multiple Sclerosis	O	O	Tuberculosis
O	O	Cancer _____	O	O	Mumps	O	O	Typhoid Fever
O	O	Chicken Pox	O		Pacemaker	O	O	Ulcers
O	O	Diabetes Type ____	O	O	Pleurisy	O	O	Venereal Disease
O	O	Emphysema	O	O	Pneumonia	O	O	Whooping Cough
O	O	Epilepsy	O	O	Polio	O	O	Other (list)
O	O	Goiter	O	O	Rheumatic Fever			

Medical History: List surgeries, major trauma, or other: _____

_____

16. Your lifestyle:

Appetite: O low O moderate O high

Regular Exercise: O never O infrequent O frequently Type: _____

Thirst for: Water: _____ glasses per day Coffee: _____ cups per day Soda: _____ glasses per day

Check all that apply to you:

O consume artificial sweetener O crave sugar O crave salty foods O stress O occupational hazards

O drink alcohol _____ glasses per Oday Oweek Omonth Oyear O use marijuana O other drugs

O tobacco _____ # per Oday Oweek Omonth Oyear

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Average Daily Menu:

Morning: _____

AM Snack: _____

Noon: _____

PM Snack: _____

Evening: _____

Evening Snack: _____

List pharmaceuticals taken in the last 2 months:

_____

_____

_____

List vitamins/supplements taken in the last 2 months:

_____

_____

_____

Continued on the next page.

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17. Your health: Check all that apply to you

	General		Head, Eyes, Ears, Nose, Throat		
O	Poor appetite	O	Glasses/contacts	O	Swollen glands
O	Heavy appetite	O	Eye strain	O	Lumps in throat
O	Strongly like cold drinks	O	Eye pain	O	Enlarged thyroid
O	Strongly like hot drinks	O	Red eyes	O	Nose bleeds
O	Recent weight loss/gain	O	Itchy eyes	O	Ringing in ears
O	Poor sleep	O	Spots in eyes	O	Poor hearing
O	Heavy sleep	O	Poor vision	O	Earaches
O	Dream-disturbed sleep	O	Blurred vision	O	Headaches
O	Fatigue	O	Night blindness	O	Migraines
O	Lack of strength	O	Glaucoma	O	Concussions
O	Body heaviness	O	Cataracts	O	Other head or neck problems: Describe
O	Cold hands or feet	O	Teeth problems		
O	Poor circulations	O	Grinding teeth		
O	Shortness of breath	O	TMJ		
O	Fever	O	Facial pain		
O	Chills	O	Gum problems		
O	Night sweats	O	Sores on lips or tongue		
O	Sweat easily	O	Dry mouth		
O	Muscle cramps	O	Excessive saliva		
O	Vertigo or dizziness	O	Sinus problems		
O	Bleed or bruise easily	O	Recurrent sore throat		
O	Peculiar taste: Describe:	O	Excessive phlegm: Describe color:		

	Respitory		Cardiovascular		Musculoskeletal
O	Difficulty breathing when lying down	O	High blood pressure	O	Neck/shoulder pain
O	Shortness of breath	O	Blood clots	O	Muscle pain
O	Tight chest	O	Low blood pressure	O	Upper back pain
O	Asthma/wheezing	O	Fainting	O	Lower back pain
O	Cough: wet or dry	O	Chest pain	O	Joint pain
O	Cough: thick or thin	O	Shortness of breath	O	Rib pain
O	Phlegm Color:	O	Difficulty breathing	O	Limited range of motion
O	Coughing blood	O	Tachycardia	O	Limited use
O	Pneumonia	O	Heart palpitations	O	Other: Describe:
		O	Phelbitis		
		O	Irregular heartbeat		

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	Skin & Hair		Neuropsychological		Genito-urinary
O	Rashes	O	Seizures	O	Pain on urination
O	Hives	O	Numbness	O	Frequent urination
O	Ulcerations	O	Tics	O	Urgent urination
O	Eczema	O	Poor memory	O	Blood in urine
O	Psoriasis	O	Depression	O	Unable to hold urine
O	Acne	O	Anxiety	O	Incomplete urine
O	Dandruff	O	Irritability	O	Venereal disease
O	Itching	O	Easily stressed	O	Bedwetting
O	Hair loss	O	Abuse survivor	O	Wake to urinate
O	Change in hair/skin texture	O	Considered/attempted suicide	O	Increased libido
O	Fungal infections	O	Seeing a therapist	O	Decreased libido
O	Other: Describe	O	Other: Describe	O	Kidney stone
	_____		_____	O	Impotence
				O	Premature ejaculation
				O	Nocturnal emission

	Gastrointestinal				Gynecology
O	Nausea	O	Hemorrhoids	O	Age menses began _____
O	Vomiting	O	Anal fissures	O	Length of cycle (day 1 to day 1)
O	Acid regurgitation	O	Bowel Movements:	O	
O	Gas	O	Frequency_____	O	Duration of flow: _____
O	Hiccup	O	Color _____	O	Irregular periods
O	Bloating	O	Texture/form _____	O	Painful periods
O	Bad breath	O	Odor _____	O	PMS
O	Diarrhea			O	Vaginal discharge: color ___
O	Constipation			O	Vaginal odor
O	Laxative use			O	Clots
O	Black stools			O	Breast lumps
O	Bloody stools				# of pregnancies _____
O	Mucous in stools				# of live births _____
O	Intestinal pain/cramping				# of premature births _____
O	Itchy anus				Age at Menopause
O	Burning anus				Date of last PAP _____
O	Rectal pain				Date last period began _____

Name any other symptoms and/or additional remarks/comments: _____

_____

_____

_____

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18. Consent

I, the undersigned, hereby authorize Christian Hunt of Chopstix to perform the following specific procedures:

Acupuncture: Insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

Herbal Prescriptions: May be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given internally or as a wash. Herbal formulas may include shell, mineral, or animal materials. If you do not want animal-based materials in your formula, let Christian know.

Cupping: Cups made of glass, bamboo, or other materials are placed on the skin creating a vacuum effect involving heat or other devices. Mild bruising may occur.

Plum Blossom or Steven Star Hammer: Light tapping on a n area of the skin with a small sterile hammer, which has seven points.

Gua Sha: Rubbing or scraping an area of the body with a round instrument. Mild bruising may occur.

Moxa: Indirect burning on an acupoint using a stick, string or ball moxa to create a warming effect.

I recognize the potential benefits and risks of these procedures include:

Potential Benefits: Drugless relief of symptoms; improved balance of bodily energies which may lead prevention or elimination of presenting problem; strengthened body constitution.

Potential Risks: Discomfort, pain, infection, blistering at site of moxa use; temporary discoloration of skin; nausea, loose bowel movements, abnormal cramping; aggravating of systems existing prior to acupuncture treatment; other potential unforeseen consequences.

With this knowledge, I voluntarily consent to the above procedures, realizing that there are no guarantees given by Chopstix or Christian Hunt regarding the cure or improvement of my condition.

I hereby release Chopstix and Christian Hunt from any and all liability, which may occur in connection with the abovementioned procedures, except for the failure to perform the procedures with the appropriate medical care. I understand I am free to withdraw my consent and to discontinue my participation in these procedures at any time.

Signature_____ Today's Date _____