DeLand Community Acupuncture New Patient Paperwork

Name _____

Address _____

City/ST/Zip _____

Phone # _____ Email _____

Date of Birth _____ Today's Date _____

Sex assigned at birth: Female ___ Male ___ Intersex ___ Preferred name/pronoun: _____

Have you had acupuncture before? _____ How did you hear about us? _____

Please explain your **primary** reason for coming for acupuncture today? **LIST ONLY ONE.**

_____

How long have you had this issue? _____ Rate your pain / discomfort on a scale of 1 to 10: _____

What else are you currently doing to treat your primary complaint? _____

What do you expect from your first visit? _____

What are your longterm health and wellness goals? _____

Are you interested in Chinese Herbal Medicine in addition to acupuncture? _____

Are you on blood thinners or chemotherapy? _____ Are you pregnant? _____

Have you experienced any concussions, traumatic brain injuries, or whiplash? _____

Do you have a diagnosed neurological condition? _____

Do you have any allergies (not intolerances or sensitivities)? _____

Please provide a list medications, supplements, and surgeries.

Informed Consent and Financial Policy I hereby request and consent to the performance of acupuncture or other modalities within the scope of practice of Oriental Medicine on me by MacKenzie Lea Muir, AP, who is licensed in Florida to practice acupuncture. I understand that there are some risks to treatment, including but not limited to some bruising and/or slight bleeding, some pain at the site of the needle insertion, dizziness or fainting, or possible aggravation of existing symptoms. The risk infection is very slight, as all needles used are pre-sterilized, single-use, and disposable. I understand that results are not guaranteed. I do not expect MacKenzie Lea Muir, AP, to be able to anticipate and explain all outcomes and risks. I understand that I may stop treatments at any time. I understand that the evaluation given to me is an assessment based on the theories of Traditional Chinese Medicine. I understand that MacKenzie Lea Muir, AP, is not providing Western medical care, and that I should look to my primary care practitioner for those services. Payment is expected at the time of treatment. The cost of an acupuncture treatment is payable on a sliding scale of $15.00-$35.00, plus a one-time fee of $10.00 due at the first visit. Unless canceled at least 12 hours in advance, our policy is to charge $15.00 for missed appointments. I have read the above consent and financial policy. I have had the opportunity to discuss with MacKenzie Lea Muir, AP, the nature and purpose of acupuncture. I have had the opportunity to ask questions, and by signing I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. **Mask Policy** If you have signs of cold or flu (including fever, chills, coughing, sneezing, nausea, vomiting, diarrhea, and/or body aches) you will be required to wear a mask.

Signature _____ Date _____

Emergency Contact Name and Number _____

Western Diagnosis
□ High blood pressure
□ Diabetes
□ Fibromyalgia
□ Hypothyroid
□ Cancer _____
□ Other _____

Thirst
□ Little to no thirst
□ Always thirsty
□ Drinks in sips/takes a while to finish a drink
□ Drinks in gulps/drinks entire glass in moments
□ Always want ice in drink
□ Drinks one or more caffeinated drinks/sodas/ juice per day

Taste/Appetite
□ Bitter/sour taste in mouth
□ Dry mouth that isn't relieved by drinking
□ Lack of sense of taste
□ Craves sweet or salty
□ Little to no appetite
□ Always hungry, even shortly after eating

Ears/Nose/Throat
□ Seasonal allergies
□ Runny nose/Post nasal drip
□ Pressure in the sinuses
□ Clear/white discharge
□ Yellow/dirty discharge
□ Loss of sense of smell
□ Frequent sore throat
□ Chronic dry cough
□ Chronic mucus cough
□ Scent sensitivity
□ Dizziness or vertigo
□ Tinnitus or hearing loss

Body Temperature
□ Sweating in comfortable environments
□ Never/rarely sweat
□ Night sweats
□ Hot flashes during day
□ Often uncomfortable with the temperature when everyone else is comfortable
□ Cold hands or feet
□ Feeling of fever in the afternoon

Digestion
□ Formed stools, not dry, loose, or sticky
□ Loose/watery stools
□ Soft/sticky stools
□ Hard/dry stools
□ Dry, pellet-like stools
□ BM with strong smell
□ Sensation of abdominal bloating or fullness
□ Abdominal pain/pressure that is relieved with BM or flatulence
□ Need to bear down to have a bowel movement
□ Chronic constipation (less than once per day)
□ Frequent BM (more than once more day)
□ Regular laxative use
□ Nausea/vomiting
□ Food sensitivity
□ Excessive gas/belching
□ Acid reflux or heartburn
□ Hiatal hernia
□ Growling in the stomach that can be heard
□ Antibiotic use in the past 8 months
□ Frequent antibiotic use over lifetime or a long period of antibiotic use
□ Current or history of gall bladder stones or gall bladder removal

Urination/Fluid Metabolism
□ Pain or burning with urination
□ Foul smell with urination
□ Cloudy, sediment in urine
□ Dark yellow-orange urine
□ Need to bear down to start/ complete urination
□ Edema or swelling
□ Frequent UTIs
□ History of or current kidney stones
□ Toenail fungus
□ Known chemical or mold exposures
□ Purple, red, or blue discoloration in the lower legs and/or feet

Sleep/Energy
□ No trouble falling asleep
□ Difficulty falling asleep
□ Sleep soundly through the whole night
□ Wake often at night but easily fall back to sleep
□ Wake often at night and has trouble falling back to sleep
□ Difficulty waking in morning
□ Wake fully rested
□ Feel tired all day long
□ Feel excessively tired in the afternoon

Breathing
□ Sleep apnea
□ Snoring
□ Asthma or wheezing
□ Shortness of breath after little exertion or when speaking
□ Unconscious breath holding while doing tasks
□ Frequent sighing
□ Frequent yawning
□ Wake multiple times to urinate at night
□ Frequent mouth breathing during the day or at night

Mood/Memory
□ Anxiety/overthinking
□ Anger/frustration
□ Sadness/depression
□ PTSD/fear
□ Brain fog/poor memory
□ Easily distracted
□ Diagnosed psychiatric condition _____
□ Currently taking psychiatric medication

Lifestyle
□ Smokes cigarettes
□ Two or more alcoholic drinks per day
□ Previous/current addiction
□ Low/decreased libido
□ History of disordered eating
• # of days per week you get at least 30 minutes of exercise? _____

Pain
Location of pain:
□ Whole body joint pain
□ Whole body muscle pain
□ Headaches/migraines
□ Neck
□ Shoulder joint
□ Arm
□ Elbow
□ Hand, wrist, or fingers
□ Upper or middle back
□ Low back or hip
□ Leg
□ Knee
□ Foot, ankle, or toes
Description of pain.
Circle all that apply:
aching stabbing
moving radiating
burning tingling/numb
constant comes/goes
pressure electric
What decreases the pain?
Circle all that apply;
heat ice massage
rest/sleep exercise
stretching medication
weather changes
What increases the pain?
Circle all that apply:
heat ice massage
rest/sleep exercise
stretching medication
weather changes

Gynecology
□ Severe mood changes before/during cycle
□ Heavy bleeding/clotting
□ Cramping
□ Chronic yeast infections
□ Peri or postmenopausal
□ Hysterectomy
□ Pregnant _____ weeks
□ Infertility
□ Excessive discharge
□ PCOS
• Current day of cycle _____ out of _____ total days
• # of days bleeding _____

Andrology
□ Premature ejaculation
□ Impotence
□ Infertility
□ Enlarged prostate