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 _____

Please mark all that apply to you currently or for a prolonged period in past.

Western Diagnosis
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Hypothyroid
- ☐ Cancer _____
- ☐ Other _____

Thirst
- ☐ Little to no thirst
- ☐ Always thirsty
- ☐ Drinks in sips
- ☐ Drinks in gulps
- ☐ Prefer cold drinks
- ☐ Prefer hot drinks

Taste/Appetite
- ☐ Strange taste in mouth
- ☐ Dry mouth
- ☐ Lack of sense of taste
- ☐ Cravings _____
- ☐ Little to no appetite
- ☐ Always hungry

Ears/Nose/Throat
- ☐ Seasonal allergies
- ☐ Runny nose
- ☐ Post nasal drip
- ☐ Pressure in the sinuses
- ☐ Loss of sense of smell
- ☐ Chronic cough
- ☐ Dizziness or vertigo
- ☐ Tinnitus or hearing loss

Body Temperature
- ☐ Never/rarely sweat
- ☐ Night sweats
- ☐ Hot flashes during day
- ☐ Cold hands or feet
- ☐ Feeling of fever in the afternoon
- ☐ Cold in warm places

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

Digestion
- ☐ Formed/regular stools
- ☐ Loose/soft stools
- ☐ Dry, pellet-like stools
- ☐ Frequent bloating
- ☐ Need to bear down to have BM
- ☐ Chronic constipation
- ☐ Frequent BM (2+/day)
- ☐ Nausea/vomiting
- ☐ Food sensitivity
- ☐ Excessive gas/belching
- ☐ Acid reflux or heartburn
- ☐ Hiatal hernia
- ☐ History of antibiotic use over prolonged period
- ☐ Gall stones or gall bladder removal

Urination/Fluid Metabolism
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Clear urine
- ☐ Dark/brownish urine
- ☐ Need to bear down to start/complete urination
- ☐ Edema or swelling
- ☐ Frequent UTIs
- ☐ Kidney stones
- ☐ Toenail fungus
- ☐ Chemical/mold exposures
- ☐ Purple, red, or blue discoloration in the lower legs and/or feet

Lifestyle
- ☐ Smokes cigarettes/vapes
- ☐ 2+ alcoholic drinks/day
- ☐ History of addiction
- ☐ History of eating disorder
- • # of times per week you exercise? _____
- • Do you regularly practice hobbies/activities that you enjoy? _____

Sleep/Energy
- ☐ No trouble falling asleep
- ☐ Difficulty falling asleep
- ☐ Sleep soundly through the whole night
- ☐ Wakes 2+ times at night
- ☐ Frequent afternoon naps
- ☐ Good energy all day
- ☐ Feel tired all day long
- ☐ Excessively tired in 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
- ☐ Frequent mouth breathing during the day or at night

Gynecology
- ☐ Severe mood changes before/during cycle
- ☐ Heavy bleeding/clotting
- ☐ Cramping
- ☐ Yeast infections
- ☐ Peri/postmenopausal
- ☐ Hysterectomy
- ☐ Pregnant ____ weeks
- ☐ Infertility
- ☐ Excessive discharge
- ☐ PCOS
- ☐ Endometriosis
- • Current day of cycle _____ out of _____ total days
- • # of days bleeding _____

Andrology
- ☐ Premature ejaculation
- ☐ Impotence
- ☐ Infertility
- ☐ Enlarged prostate

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

Do Not Write in Box