

# ACUPUNCTURE for the PEOPLE

## HEALTH HISTORY

Date: \_\_\_ / \_\_\_ / \_\_\_

Name:				Sex:		Age:	
Address:			City:		State:	Zip Code:	
Phone #1: Home Cell Other		Phone #2: Work Cell Other		Email:			
Date of Birth:		Emergency Contact: (name & relationship)			Phone #:		
Height:		Weight:		Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other : _____			
Occupation:				Employer:			
How did you hear of our clinic?: <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Craigslist <input type="checkbox"/> Flyer <input type="checkbox"/> Walk / Drive by <input type="checkbox"/> Print Ad <input type="checkbox"/> Other : _____				Referred by:			
Physician: _____ Phone #: _____				Have you been treated by Acupuncture or Oriental Medicine Before? <input type="checkbox"/> No <input type="checkbox"/> Yes ___ / ___ / ___			

### MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1


---

10

2

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1


---

10

3

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1


---

10

### HEALTH HISTORY

Circle the if you have / had the condition and note the year it started.  
Circle the if there is a family history of the condition.

	YOU	Year	FAMILY		YOU	Year	FAMILY
Cancer type(s)?	↑	_____		Osteoporosis	↑	_____	
Diabetes	↑	_____		Herpes	↑	_____	
Hepatitis	↑	_____		AIDS / HIV	↑	_____	
High Blood Pressure	↑	_____		Other STD	↑	_____	
Heart Disease	↑	_____		Rheumatic Fever	↑	_____	
Stroke	↑	_____		Alcoholism	↑	_____	
Seizure Disorder	↑	_____		Allergies type(s)?	↑	_____	
Thyroid Disease	↑	_____		Mental Illness	↑	_____	
Asthma	↑	_____		Kidney Disease	↑	_____	
Pacemaker	↑	_____		Anemia	↑	_____	

### HABITS

Amount / Week	If Quit, Year?
Coffee / Tea _____	_____
Soda _____	_____
Tobacco _____	_____
Alcohol _____	_____
Drugs _____	_____

### EXERCISE

Do you exercise regularly?  Yes  No

If so, what and how often:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates:

### MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



ACUPUNCTURE for the PEOPLE  
HEALTH HISTORY FOR WOMEN



Please mark an X on the scales and check any boxes of symptoms you have had in the past month

**TEMPERATURE**

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD

HOT

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Thirst for cold / hot drinks | <input type="checkbox"/> Night sweats   | <input type="checkbox"/> Hot hands, feet, chest |
| <input type="checkbox"/> Chills              | <input type="checkbox"/> Thirst, no desire to drink   | <input type="checkbox"/> Unusual sweats | <input type="checkbox"/> Hot flashes            |
| <input type="checkbox"/> Cold "in the bones" | <input type="checkbox"/> Absence of thirst            | When _____ am / pm                      | <input type="checkbox"/> Hot in afternoon       |
| <input type="checkbox"/> Areas of numbness   | <input type="checkbox"/> Excessive thirst             | Where on body _____                     | <input type="checkbox"/> Hot at night           |

**MOISTURE**

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY

OILY

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Dry skin          | <input type="checkbox"/> Dry mouth             | <input type="checkbox"/> Edema / Swelling _____ | <input type="checkbox"/> Oily skin          |
| <input type="checkbox"/> Dry hair          | <input type="checkbox"/> Dry lips              | <input type="checkbox"/> Rashes _____           | <input type="checkbox"/> Oily hair          |
| <input type="checkbox"/> Dry eyes          | <input type="checkbox"/> Dry throat            | <input type="checkbox"/> Itching _____          | <input type="checkbox"/> Pimples            |
| <input type="checkbox"/> Dry brittle nails | <input type="checkbox"/> Dry nose / Nosebleeds | <input type="checkbox"/> Dandruff               | <input type="checkbox"/> Weight gain / loss |
- Where on your body?:

**DIGESTION**

DIARRHEA

CONSTIPATION

- |  |  |  |   |
|--|--|--|---|
| BM: How often? _____ x / every _____ days                                | <input type="checkbox"/> Gas           | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Dry Stools           |
| Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Bloating      | <input type="checkbox"/> Bad breath        | <input type="checkbox"/> Difficult to pass    |
| <input type="checkbox"/> Alternating diarrhea & constipation (IBS)       | <input type="checkbox"/> Belching      | <input type="checkbox"/> Heartburn         | <input type="checkbox"/> Tired after BM       |
| <input type="checkbox"/> Indigestion                                     | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Excessive hunger  | <input type="checkbox"/> Foul smelling stools |

**ENERGY**

LOW

HIGH

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Sudden energy drop       | <input type="checkbox"/> Dependence on caffeine / stimulants | <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Hard to concentrate      |
| Time of day: _____ am / pm                        | <input type="checkbox"/> Wired / ungrounded feeling          | <input type="checkbox"/> Heart Palpitations        | <input type="checkbox"/> Poor memory              |
| <input type="checkbox"/> Energy drop after eating | <input type="checkbox"/> Body / Limbs feel heavy             | <input type="checkbox"/> Blood pressure High / Low | <input type="checkbox"/> Dizziness / lightheaded  |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Body / Limbs feel weak              | <input type="checkbox"/> Bleed / Bruise easy       | <input type="checkbox"/> Headaches _____ x / week |

**SLEEP**

- # hours per night \_\_\_\_\_
- Difficulty falling asleep
- Wake \_\_\_\_\_ x / night @ \_\_\_\_\_ am / pm
- Wake to urinate How often? \_\_\_\_\_
- Disturbing dreams
- Restless sleep
- Not rested upon waking

**EMOTIONS**

What emotion(s) dominate your experience?

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Anger              | <input type="checkbox"/> Grief       |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Joy         |
| <input type="checkbox"/> Worry              | <input type="checkbox"/> Fear        |
| <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Timid / shy |
| <input type="checkbox"/> Sadness            | <input type="checkbox"/> Indecision  |

**EYES, EARS NOSE THROAT**

- |   |  |
|---|--|
| <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Poor hearing    |
| <input type="checkbox"/> Night blindness        | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red eyes               | <input type="checkbox"/> Excess earwax   |
| <input type="checkbox"/> Itchy eyes             | <input type="checkbox"/> Sore throat     |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Sinus congestion       | <input type="checkbox"/> Mouth sores     |
| <input type="checkbox"/> Phlegm (color _____)   | <input type="checkbox"/> Cough           |

**MENSES**

- Age at first menses: \_\_\_\_\_
- Length of full cycle: \_\_\_\_\_ days
- Length of menses: \_\_\_\_\_ days
- Last menses start date: \_\_\_\_\_ / \_\_\_\_\_
- # of pregnancies: \_\_\_\_\_
- # of births: \_\_\_\_\_ premature \_\_\_\_\_
- # of abortions / miscarriages: \_\_\_\_\_

**MENOPAUSE**

Age at last menses : \_\_\_\_\_  Hot flashes \_\_\_\_\_ x / day  Vaginal dryness

Year changes began: \_\_\_\_\_  Night sweats \_\_\_\_\_ x / week  Loss of sex drive

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heavy periods                                      | <input type="checkbox"/> Cramps            | <input type="checkbox"/> Mood changes                  |
| <input type="checkbox"/> Light periods                                      | <input type="checkbox"/> Before bleeding   | <input type="checkbox"/> Fatigue w/ menses             |
| <input type="checkbox"/> Painful periods                                    | <input type="checkbox"/> First day         | <input type="checkbox"/> Digestive changes w/ menses   |
| <input type="checkbox"/> Irregular periods                                  | <input type="checkbox"/> During period     | <input type="checkbox"/> Midcycle spotting             |
| <input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS) | <input type="checkbox"/> Clots             | <input type="checkbox"/> Yeast infections              |
|   | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Birth control pill (hormonal) |

## ACUPUNCTURE for the PEOPLE

### **Consent for Treatment by Traditional Chinese Medicine**

I, the undersigned hereby authorize the licensed Acupuncturists (L.Ac.) of *ACUPUNCTURE for the PEOPLE, LLC* to perform Chinese Medicine treatment methods which may include acupuncture, acutonics (tuning forks), moxibustion, cupping, Gua Sha, bleeding, ion pumping cords, herbal therapy, dietary and lifestyle advice.

*I understand that these treatments are all safe, natural methods of healing  
and I recognize the potential risks and benefits of these procedures as described below*

**POTENTIAL BENEFITS:** Relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of your main complaint(s).

**POTENTIAL RISKS:** *Acupuncture* – Although uncommon, there is a potential for acupuncture to cause temporary bruising, swelling, bleeding, numbness, tingling, and soreness at the needle site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage or possibly the aggravation of symptoms existing prior to treatment. Infection is a slight possibility even though our clinic uses only sterile disposable needles and maintains a clean and safe environment.

*Moxibustion* – Burning of moxa (a Chinese herb – Mugwort) on or near the body has the potential risk of burns, blistering or scarring. *Cupping and Gua Sha* – may cause temporary bruising or redness lasting a few days.

*Herbal Medicine* – Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions. Large doses taken without my practitioner's approval may be toxic and some herbs may be inappropriate during pregnancy.

**PREGNANCY:** Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process and postpartum. I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points or herbs that could induce premature labor or miscarriage.

**CANCELATION POLICY:** I recognize that scheduling an appointment involves the reservation of time specifically for me and I agree to give at least 24 hours notice to cancel or reschedule an appointment. *A no-show fee of \$15 will be charged for sessions missed without such advance notification.*

**PRIVACY:** Since several people are being treated in the same room at once it is vital that we work together to respect your privacy and the privacy of others. Let us know if there are certain topics that need extra discretion or if you prefer to do your intake in a more private setting. If you happen to overhear someone else's private information, please keep it to yourself, you'd want others to do the same for you.

*With this knowledge, I voluntarily consent to the above procedures and policies, realizing that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments regarding the cure or improvement of my conditions. I hereby release ACUPUNCTURE for the PEOPLE, LLC and its practitioners from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.*

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Print Name

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Signature of Client  
or Person Authorized to Consent

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Date

# Please...

- 🕒 Try to arrive a few minutes early to relax, check in, have some water or visit the restroom if you need to.
- 🕒 Fill out any necessary paperwork and bring it with you to your appointment. (You may arrive 20 minutes early to fill them out at the office)
- 🕒 Make sure to have something to eat 1 to 2 hours before your appointment (don't arrive on an empty stomach).
- 🕒 Wear loose, comfortable clothing that can be pulled up above the knees and elbows. Wear a tanktop if your acupuncturist needs access to your neck or shoulders.
- 🕒 If you brush your tongue or usually wear make-up, try to skip it the day of your treatment to allow for a more realistic assessment. And please no oils or perfumes.
- 🕒 Avoid coffee, alcohol, sugar, and greasy foods before your treatments.
- 🕒 Silence your cell phone or pager while you are at the clinic
- 🕒 Talk in a soft voice to maintain a relaxing atmosphere and not disturb other clients.
- 🕒 Respect the privacy of other clients - if you happen to overhear someone else's private information, please keep it to yourself - you'd want others to do the same for you.
- 🕒 Let us know if you need to be somewhere after your treatment so we can make sure that you're out on time.

**Thank You.**  
for supporting  
Community  
Acupuncture

**2833 Willamette St. Suite E**  
**AcupunctureForThePeople.org**  
**(541) 521-6285**

## About Your Acupuncture Treatment

Your first visit will last about 1 ½ to 2 hours (return visits are only an hour long). We'll begin by asking about your health history and current condition. Next, you'll be asked to stick out your tongue and we'll listen to the pulses of both wrists. While the acupuncturist develops a diagnosis and treatment plan you can remove your shoes, roll up your pants and relax on a treatment table or comfy recliner.

The treatment is simple and only takes a few minutes. We only use sterile, disposable needles that are super thin (like a cat's whisker). They come inside a small plastic tube that we place on the acupuncture point and then tap the needle in place. As we guide it to the right spot, the energy in your body will gather at the point. You may feel a dull ache, a warm tingling sensation, or electrical impulses that travel up or down the body. This means that the point is being activated and is not only normal, but expected.

Your comfort is important to us, so please communicate what you're experiencing. Pain is not a part of the therapeutic response so if you feel a sharp or poking sensation let us know. It's common during insertion to feel very slight prick that will subside quickly, but occasionally the needle will enter a hair follicle. This may feel like a pinch or a mosquito bite. In this rare case, the needle will be removed, and we'll try that point again later. Most sensations will subside quickly and you may even forget that the needles are there!

Once all the points are in, we'll make sure you're comfortable and warm enough before we leave you to rest and let the needles do their job. Try not to move with the needles in, just relax and take a nap if you like. After about 30-45 minutes you'll notice the relaxation coming to an end, your eyes want to stay open and you feel ready to get up. Just make eye contact and your acupuncturist will remove the needles.

Take your time getting up and composing yourself to re-enter the outside world. Some people feel rejuvenated & energized, others report a 'spacey, blissed out feeling' after acupuncture. It's not uncommon to feel tired after the treatment, so plan your day accordingly.

We'll discuss a treatment plan and schedule future appointments. Your first visit is a sliding scale of \$30-50, and return treatments are \$15-35. You decide what to pay. On the reception desk you'll find a little red envelope with your name on it. Put your payment in the envelope and drop it through the slot in the wooden box. We accept cash and checks. Be sure to let us know if you need change and make checks payable to "Acupuncture for the People."

If for any reason you need to cancel or reschedule an appointment, please give at least 24 hours notice or you will be charged a \$15 fee for that appointment.