Striving FOR Health

Acupuncture Initial Intake Form

Name:_____ Date:_____

Address:_____

Home phone number:_____ Cell number:_____

Email address:_____

Occupation:_____ Age:_____ DOB:_____

Emergency Contact:_____ Phone:_____

Are you currently receiving health care?_____Is it helping?_____

Name of physician or practitioner:_____

Condition being treated:_____

How did you hear about the clinic?_____

Would you like to receive our newsletter via email? _____

Chief complaint, injury, illness or symptoms:

_____

_____

_____

_____

When did it start?_____ Is this a recurring issue?_____

What makes it better?_____

What makes it worse?_____

Have you received treatment for this before?_____ When?_____

If so, how was it treated?_____Did it help?_____

Any additional comments about issue?_____

_____

Personal Medical History:

Any major surgeries, illnesses, or accidents? If so, please list with dates.

_____

_____

Any contagious diseases? If so, please list. (ie. HIV, Hepatitis, herpes, etc)

_____

Any known allergies? If so, please list.

_____

_____

Are you currently taking any medications? If so, please list.

_____

Are you currently taking any supplements, probiotics or vitamins? If so, please list.

_____

What type of vitamins are you taking?_____

General Symptoms:

Please check where applicable for symptoms

Digestion:

___ Indigestion ___ Nervous stomach ___ Bloating ___ Heartburn

___ Nausea/vomit ___ Full feeling/distention ___ Belch/burp ___ Noisy Stomach

___ Pain/cramps ___ Bad Breath ___ Gas ___ Normal

___ Other_____

Perspiration:

___ Very little ___ Easily ___ Night sweats ___ Profuse ___ Bad Smell

___ On palms ___ On feet ___ W/O exertion ___ Normal ___ Other

Bowels:

___ Loose stool ___ Blood in stool ___ Undigested food ___ Bad smell

___ Diarrhea ___ Hemorrhoids ___ Constipation ___ Anus itching

___ Mucus in stool ___ Black stool ___ Hard stools ___ Intestinal worms

___ Use laxatives ___ Colon problems ___ Pellet stool ___ Normal

___Other _____

Urination:

___ Frequent ___ Burning ___ Bladder infection ___ Urgency

___ Night time ___ Blood ___ Incontinence ___ Cloudy

___ Profuse ___ Pus ___ Strong smell ___ Scanty

___ Painful ___ Infection ___ Dark color ___ Norma

___ Other_____

Thirst:

___ Not thirsty ___ Excessive thirst ___ Prefer cold drinks ___ Prefer hot drinks

___ Thirsty but don't want to drink ___ Drink enough every day

Skin:

___ Dry ___ Hives ___ Clammy ___ Oily ___Pimples ___ Rashes

___ Skin tags ___ Itching ___ Warts ___ Eczema ___ Bruises easily ___ Normal

Other _____

Hair:

___ Dry ___ Oily ___ Dandruff ___ Early grey ___ Falling out

___ Normal Other_____

Nails:

___ Soft ___ Spots ___ Grows slowly ___ Pale ___ Breaks easily

___ Purple ___ Ridges ___ Grows fast ___ Lines ___ Normal

Ears:

___ Poor hearing ___ Ear aches ___ Ringing (high pitch) ___ Flaking

___ Discharges ___ Itching ___ Ringing (low pitch) ___ Normal

Eyes:

___ Wears glasses ___ Swollen eyelid ___ Cataract ___ Red ___ Dry

___ Spots in vision ___ Inflammation ___ Glaucoma ___ Itchy ___ Twitch

___ Yellow ___ Poor night vision ___ Sensitive to light ___ Pain ___ Tears

___ Dark Circles ___ Blurry vision ___ Color blindness ___ Strain ___ Normal

___ Other _____

Nose:

___ Stuffy nose ___ Hay fever ___ Sneezing ___Mucus ___Bleeding

___ Loss of smell ___ Sinusitis ___ Itchy nose ___ Dry nose ___ Rhinitis

___ Normal ___ Other _____

Mouth & Throat:

___ Dry ___ Gum problems ___ Frequent sore throat ___ Hoarseness

___ Sores in mouth ___ Hiccups ___ Sores in the mouth ___ Dry lips

___ Swollen glands ___ Grind teeth ___ Sores on tongue ___ Drools a lot

___ Frequent colds ___ Lump in throat ___ Thyroid issues ___ Teeth issues

___ Normal ___ Other_____

Respiratory:

___ Asthma ___ Difficulty inhaling ___Excess sighing ___ Dry cough

___ Chest pain ___ Difficulty exhaling ___ Hx Bronchititis ___Cough w/mucus

___ Chest tightness ___Difficulty breathing when lying down ___ Cough w/blood

___ Normal ___ Other_____

Cardiovascular - Circulation:

___ Diagnosed Heart issues ___ Palpitations ___ Bleeds easily ___ Chest pain

___ Low blood pressure ___ Murmur ___ Varicose veins ___ Ankle swelling

___ High blood pressure ___ Bruise easily ___ Hx of anemia ___ Facial swelling

___ Broken blood vessels or capillaries ___ High cholesterol ___ Hand swelling

___ Numbness in extremities___ Spider veins ___ Slow heart beat ___ Irr. Heart beat

___ Normal ___ Other_____

Pain:

___ Low back ___ Mid back ___ Upper back ___Hips ___ Torso

___ Neck ___ Spine ___ Hands ___ Wrist ___ Arms

___ Sciatica ___ Legs ___ Knees ___ Ankles ___ Feet

___ Muscle cramps ___ Nerve pain ___ Weak muscles ___ Muscle twitching

___ Normal ___ Other_____

What is the nature of the pain? (sharp, dull, cold, hot, continuous, comes and goes)

_____

What makes it better?_____

What makes it worse?_____

How long have you had the pain?_____

Lifestyle Questions **Please check where applicable.**

Daily or weekly habits:

___ Cigarettes ___ Cigars ___ Soft drinks ___ Fast food ___ Salt

___ Alcohol ___ Caffeine ___ Sugar ___ Coffee ___ Water

___ Daily stress ___ Recreational drugs ___ Other_____

Exercise:

___ Never ___ Little ___ Moderate ___ Heavy

What type of exercise do you do?_____

Emotional state:

___ Happy ___ Angry ___ Sad/Depressed ___ Stressed ___ Restless

___Easily irritable ___ Cry easily ___ Laugh easily ___ Worried ___ Foggy headed

___ Difficulty making decisions ___ Hurry to get things done ___ Overwhelmed

___ Normal ___ Other_____

Appetite:

___ Up and down ___ Poor ___ Good ___ Always hungry ___ Loss of taste

Weight:

___ Under weight ___ Overweight ___ Recent gain ___ Recent loss

___ Can't gain ___ Can't lose ___ Weight gain started after 40 year of age

___ Normal weight ___ Other_____

Energy:

___ Up and down ___ Low ___ Low after eating ___ Excess ___ Normal

___ Tired in the afternoons ___ Tired in the mornings ___ Wake feeling rested

___ Feel exhausted ___ Wake feeling tired ___ Other_____

Stress Level:

___ Not stressed ___ Slightly stressed ___ Very stressed ___ Extremely stressed

Do you have an outlet for your stress?_____

Are you getting any relaxation time during the week?_____ How much?_____

Sleep:

___ Difficulty falling asleep ___ Awaken easily ___ Restless ___ Excessive dreaming

___ Nightmares ___ Always sleepy ___ Tired when getting up in the morning

___ Difficulty going back to sleep if woken ___ Other_____

How much sleep do you get each night?_____

Headache / dizziness

___ Headaches ___ Dizziness ___ Vertigo ___ Migraines ___Motion sickness

___ Poor memory ___ Poor balance ___Faints ___ Nausea

___ Bend down then stand up and get dizzy ___ Other_____

Body Temperature:

___ Warm natured ___ Flushed face ___ Warmer in the afternoon and night

___ Cold natured ___ Warm palms ___Alternate chills and fever

___ Cold hands ___ Cold feet ___ Normal

Diet: Please use 1 check if eaten daily and 2 checks if eaten weekly.

___ Meats	___ Poultry	___ Fish	___ Whole grains	___ Dairy products
___ Soy products	___ Fruits	___ Sweets	___ Fried foods	___ Hot spicy foods
___ Vegetables	___ Salads	___ Fast food	___ Cold food	___ Soft drinks
___Fats/oils	___Caffeine	___ Coffee	___ Chips/snacks	___ Refined grains
___Alcohol	___ Salt	___ Sugar	___ Nuts/Seeds	___Beans/Legumes

Do you crave any specific foods?_____

Do you eat full meals or just snack during the day?_____

What is a typical breakfast?_____

What is a typical lunch?_____

What is a typical dinner?_____

What are typical snacks through the day?_____

What are your favorite foods?_____

What foods do you dislike?_____

Do you have a favorite flavor? ___ Sweet ___ Sour ___ Bitter ___ Salty ___ Pungent

Are you on a specific diet?_____ Why?_____

How much water do you drink each day?_____

Is your diet heavy with any one group of food?_____

How many servings of fruit and vegetables are you getting every day?_____

How are you getting them in your diet? _____

Are they mostly eaten raw or cooked?_____

What are your preferred methods of cooking?

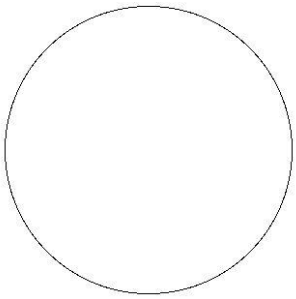
___Steaming ___Boiling ___Baking ___Frying ___Sautéing ___Slow cooker ___Wok

Do you cook at home or eat out more often?_____

How often are you eating out each week?_____

Please make a pie graph on the circle below showing your approximate ratios of what you ate yesterday:

Meats/protein -- Fats/oils -- Sweets/sugar -- Fruits/vegetables -- Breads/pasta – Dairy



For women only:

Are you currently pregnant?_____ If so, when are you due?_____

Are you currently nursing?_____ If so, for how long?_____

Do you have kids?_____ If so, how many and how old are they?_____

Any complications with the pregnancy?_____

Any complications with the delivery?_____

_____

Any past gynecological surgeries or issues?_____ If so, what were they?_____

_____

What is your normal cycle?_____ Are you taking birth control pills?_____

Please check where applicable.

Menstruation cycle issues (before or after menses):

___ Irregular cycle ___ Painful ___ Heavy flow ___ Scanty flow ___ Diarrhea

___ Clotting ___Cramps ___ PMS Symptoms ___ H2O Retention ___ Sighing

___ Irritable ___ Breast tenderness or pain ___ Constipation ___Bloating

___ Emotional ___ Other_____

Vaginal Discharges:

___ Yellow ___ White ___ Clear ___ Red ___ Thick ___ Thin

Is the discharge only at ovulation?_____ If not, when?_____

Any other symptoms at ovulation?_____

Menopausal symptoms:

When did menopause start?_____ How long did it last?_____

Are you currently experiencing symptoms? _____ Have you had a hysterectomy?_____

___ Hot flashes ___ Night sweats ___ Dry skin ___ Insomnia ___ Irritability

___ Emotional ___ Vaginal dryness ___ Fatigue ___ Anxiety ___ Mood swings

___ Weight gain ___ Depression ___ Other _____

Striving FOR Health

Informed Consent for Treatment

DeBritt Ealey, L.Ac. VA License #0121000524

I hereby request and consent to the treatment of acupuncture and any other procedure within the scope of practice of Traditional Chinese Medicine at Striving for Health. I consent to treatment for myself (or for the client named below, for whom I am legally responsible) by DeBritt Ealey, L.Ac. and/or any other licensed acupuncturists who now or in the future may treat me while employed by, working or associated with Striving for Health or serving as back up for DeBritt Ealey at any location.

I understand that methods of treatment within the scope of Traditional Chinese Medicine may include, but are not limited to: acupuncture (treatment with needles), acupressure point stimulation (manual or external device), electrical stimulation (TENS/ MENS), moxibustion (indirect or direct application of heat to acupuncture points or needles), cupping (cups made of plastic or glass placed on the skin forming a suction), Tui-na (Chinese massage), Gua sha (Chinese dermal friction technique), herbal medicine, dietary therapy, and cosmetic acupuncture.

I have been informed that acupuncture is a generally safe method of treatment but that it may have some possible side effects, although rare, that can include: bruising, numbness or tingling near the needle site that may last for a few days, dizziness or fainting, and needle sickness or shock. Most clients do not experience any complications with treatment.

Acupuncture/Cupping/ Gua Sha:

In very rare instances needles can break. Bleeding or bruising can be a side effect with acupuncture as well as possible nerve injury and needle shock. These side effects are rare, but possible. Bruising is a very common side effect after a cupping or gua sha treatment. Infection is another low but possible risk, however, this clinic ONLY uses sterilized single use needles and practices in a clean environment to reduce this chance even further. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

Herbal Therapy:

The herbs and nutritional supplements recommended (which can be from food, plant, animal or mineral sources) are considered to be very safe. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and/or tingling of the tongue. I understand that some herbs may interact with prescription medications, over-the-counter medications, or supplements; therefore, I will notify the acupuncturist named above if I am taking any medication or supplements concurrently with herbs. I understand that some herbs may be inappropriate during pregnancy.

Cosmetic Acupuncture:

All side effect possibilities of acupuncture apply as well as the possibility of asymmetry due to a pre-existing natural asymmetry, previous injuries on the side of the face/body, or severity of symptoms from one side or the other. Direct needling or a microneedling roller may be used, depending on the needs of the patient. If microneedling is done, side effects are minimal but typically include redness, dryness, minor flaking or itching for 24 to 72 hours after the treatment. If the patient experiences cold sore, needling on the face could bring on an outbreak so let us know. During post treatment massage of the face, topical applications of organic products or herbs may be used so there is always a small chance of a local allergic reaction. Sample skin testing of the substance is done prior to application to help decrease this risk. I understand that cosmetic acupuncture results are much slower and less pronounced than with surgical or laser procedures, derma fillers or Botox, therefore I cannot expect the same level of change or the immediate results received from these other therapies.

Microcurrent (MENS) Treatments:

This is an extremely safe procedure. It has been used for over 50 year and is an FDA approved device. This therapy is used for pain issues (chronic and acute) and for Facial Rejuvenation treatments as an anti-aging procedure. Patients should not get this procedure if they have a pacemaker, insulin pump, are pregnant, have epilepsy or experience seizures, have a metal implant at treatment site, have phlebitis, thrombosis, or varicose veins, have cancer, experience cold sore breakouts, or have an active infection at the treatment site. For treatment of pain, several treatments may be needed before results are seen. For the Facial Rejuvenation treatments, I understand that results are slower and less pronounced than with surgical or laser procedures, derma fillers or Botox, therefore I cannot expect the same level of change, or the immediate results received from these other therapies.

Gut Restoration / Dietary Therapy:
This is a specific protocol geared towards improving the health of the gut microbiome. It utilizes specific supplements to aid, balance, support and heal the gut. This is done in combination with dietary changes with the goal of expanding the dietary diversity which will help to support the overall health of the person being treated.

I understand that everyone responds differently to treatment, no matter what treatment is done, and results may vary. I will notify the acupuncturist and/or clinic if I am or if I become pregnant. Clients with severe bleeding disorders, diabetes, lymph edema, or infectious diseases such as HIV/AIDS, hepatitis, or tuberculosis should inform the acupuncturist prior to any treatment.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist's professional knowledge and judgment to determine and provide the best treatment for me, based upon the facts known at the time of treatment. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical diagnosis or care and that I should look to my Western primary care practitioner (ie:MD) for those services and for routine checkups.

I understand that the acupuncturist may review my patient records and lab reports.

By voluntarily signing below, I acknowledge that I have read or had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures within Traditional Chinese Medicine and have had the opportunity to ask questions about any of this with my acupuncturist. I intend this consent form to cover the entire course of my treatment for my present symptoms and conditions and for any future symptoms and conditions for which I seek treatment.

I also understand that there is a cancelation policy. If I cancel or reschedule my appointment within 24 hours of my scheduled time or don't show up for a scheduled appointment, I will be charged a $75 fee.

Signed_____ Date_____

Printed Name_____

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debritt@strivingforhealth.com | www.strivingforhealth.com

Striving FOR Health

Authorization to Release Health Information

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patients.

Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of the office. In accordance with the Notice of Privacy Practices, this office via this authorization form, requests that the patients indicate below to authorize the release of his/her health information. This office doesn't accept insurance so the need to have any records released outside of the office is very rare.

I, the undersigned, understand that I have the right to:

- Refuse to sign this authorization
- Receive a copy of the authorization
- Restrict what is disclosed by this authorization
- Inspect or request an amendment of the health information to be disclosed
- Revoke this authorization, by written notice
- Be notified if any records are requested

I recognize that once disclosed, my health information is no longer under the control of this practitioner/clinic. While I understand that the practitioners/clinic will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by this office's privacy practices.

I understand that whether or not I sign this document, it will not affect my treatment at this practice or the payments I incur. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Right for my state at: http://www.hhs.gov/ocr/regmail.html

I hereby authorize this office to disclose my health information as described in this document.

_____ _____

Name of Client Contact Number

_____ _____

Signature Date

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Diagnostic Examination Release

As an acupuncturist licensed in the state of Virginia, it is required that I ask if you have received a diagnostic examination within the past six months by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s) that we will be addressing in this office.

I have seen a doctor about my issue(s):_____

_____

If not, I am instructed to recommend that you get a diagnostic examination by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s)that we will be addressing in this office.

I have read and understand this information.

_____ _____

Signature Date

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