Today's Date__/___/___

Catalyst Acupuncture & Wellness LLC
New Patient Intake Form

Last Name:_____First Name:_____Birth Date:___/___/_____

Address:_____

City:_____State:_____Zip:_____

Best Phone:_____ Alternate:_____

Occupation:_____ email:_____

Emergency Contact:_____Phone:_____

Physician:_____Phone:_____

Physician's Diagnosis: _____

Allergies:_____

List all Medications and Supplements you are currently taking, dosage & frequency

Medications	**Supplements**

Habits	Heavy	Moderate	Light	None
Caffeinated Beverages or food				
Smoking				
Alcohol				
Exercise				

Updated 12/30/2019

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1. Reason for today's visit?_____

_____

2. Is there anything that has been able to change your condition in any way? Yes No

If yes describe: _____

3. When did this issue first occur? _____

4. Is it constant or does it come and go? _____

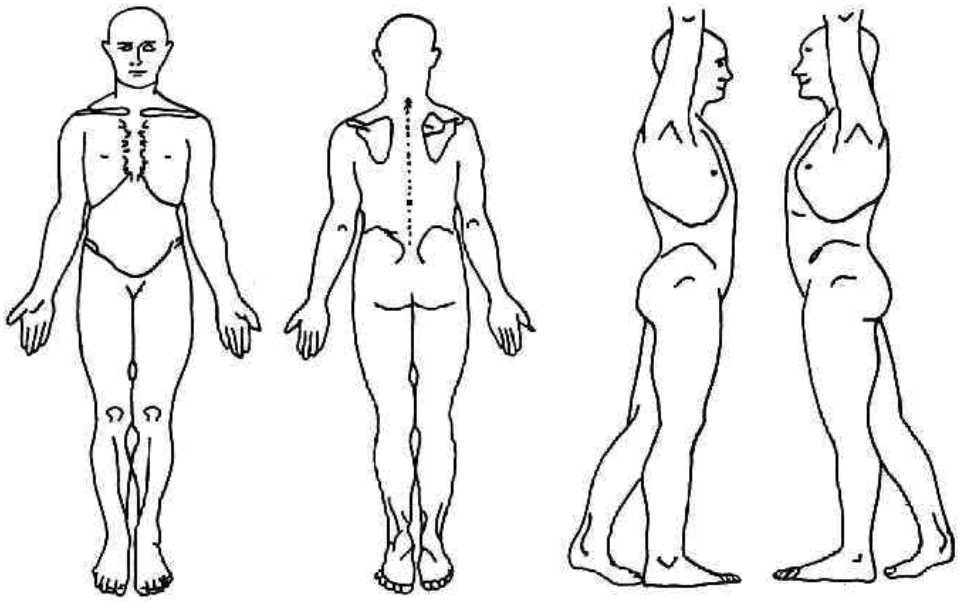
5. If applicable, does it move?_____

6. Do you have a history of chronic pain? _____

7. Are you experiencing pain right now? _____

If yes what number best describes your pain ? |——————————————————|
0 1 2 3 4 5 6 7 8 9 10

Please mark on diagram any areas of pain



8. What frequency is the pain? Constant____ Intermittent ____

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9. What makes it feel better? Check all that apply:

Heat ____ Pressure ____ Movement ____

Cold ____ Massage ____ Rest ____ Other _____

10. Are you affected by seasonal changes? Please describe _____

_____

11. Other concerns you would like to discuss and possibly address: _____

_____

12. Surgery/Scars_____

_____

13. Accidents: _____

14. Describe Your Sleep Habits

Number of hours per night you sleep	_____	Do you awake very early and are unable to go back to sleep?	Yes No
Do you have trouble falling asleep?	Yes No	Do you wake up frequently? If so when?	Yes No _____

15. Describe Your Bowel Habits : regular _____(times per day) _____
constipation____ diarrhea _____

16. If you suffer from constipation,

a. Do you feel better or worse immediately after moving your bowels? _____
b. How many days pass before you move your bowels? _____

17. If you suffer from diarrhea,

a. Does it occur early in the morning when you first wake up? _____
b. Does your rectum burn as the stool exits? _____
c. How many episodes of diarrhea do you have per day? _____

18. Do you experience abdominal pain? _____

a. If yes, what makes it better? Please check all that apply

Heat _____ Eating _____ Rest _____ Massage _____
Cold _____ Not eating _____ Movement _____ Other _____

19. How would you rate your ability to concentrate/ maintain focused thinking, and have mental clarity of thought?

Excellent ____ Good ____ Fair ____ Poor____

20. Do you have any emotional issues? Please check all that apply.

Anxiety	_____	Mania	_____
Panic attacks	_____	Mood swings	_____
Depression	_____	Seasonal affective disorder	_____
Irritability	_____	Other _____	_____

21. How many times a day do you urinate? _____

a. Color of urine: Clear_____ Pale Yellow _____ Dark Yellow _____
b. Volume: Scant _____ Normal _____ Abundant _____

22. How would you rate your appetite?

Excessive _____ Moderate/ Good _____ Poor _____

23. Do you crave Sweets? _____
Do you crave other foods? If so what types? _____

24. Do you get headaches often? _____
Do they always occur in the same location? _____

25. Do you ever experience dizziness? _____

26. Are you often thirsty? _____ Lack thirst? _____

27. What temperature do you prefer your drinks? cold____ room temp____ warm ____

28. Do you often feel cold? Yes No

Hands/ feet _____ Limbs _____ Entire body _____ Other _____

29. Describe the degree to which you sweat: very little ____ Average ____ Excessive ____

Do you sweat at night? Yes No

30. How would you rate your energy level?

Excellent ____ Good _____ Fair _____ Poor _____ Other _____

31. Have you had any lymph nodes removed? Yes No

If yes, please describe _____

32. Do you have any infectious diseases? Yes No

If yes, please list_____

_____

33. Do you have a history of drug abuse? _____

34. Do you have a history of alcohol abuse? _____

Next page for Women only, Guy's off the hook :) skip to last page

WOMEN ONLY

35. Is there a chance that you could be pregnant? _____Yes _____No

36. Are your menstrual cycles: _____Regular _____Irregular _____Early _____Late
    a. How many days is your cycle from 1st day of bleeding to last day before next period? _____days
    b. How many days does your period last? _____days
    c. Age of Menarche (first mensural cycle):_____
37. Is your flow: _____heavy _____normal _____light

38. What color is the blood: _____normal _____purplish _____dark _____light

39. Does your mensural blood contain clots? _____yes _____no
    a. If yes what color are the clots? _____bright red _____dark in color
    b. Are they larger than a quarter? _____yes _____no

40. Do you have vaginal discharge? If yes please describe:
    _____clear _____white and thin _____yellow and thick

41. Do you have itching or soreness of the vagina? _____yes _____no

42. If you generally experience mood swings, use the choices below to describe how they are around the time of your menses (please check one)
    _____better _____worse _____same _____not applicable

43. Number of pregnancies:_____ Number of miscarriages:_____ Number of abortions_____

44. Do you have symptoms that only appear prior to your period?_____
    if yes are they _____sore/ swollen breasts _____mood swings _____headaches _____bloating _____anger _____sadness _____other

Signed:_____ **Date** ____/____/____

Informed Consent Form

Nature of Treatment: Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, dermal friction (Gua Sha), info-red (heat lamps), essential oils, dietary counseling based on the fundamentals of Chinese medicine.

Purpose of Treatment: The purpose of the treatment is to resolve your complaint, I.e. the reason that you are seeking treatment. Acupuncture is a health care service that is based on oriental systems of medical theory. Diagnosis and treatment based on these theories are used to promote health and treat organic functional disorders.

Benefit of Treatment: Acupuncture and Oriental Medicine procedures have been used effectively to treat diseases for hundreds of years. The World Health Organization lists 43 conditions, which may effectively be treated my Chinese medical methods. These include musculoskeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc… I cannot guarantee the outcome of any course of treatment.

Risk of Treatment: Acupuncture and Oriental Medicine have been shown to be relatively safe. However, these are some uncommon but potential risks. These potential risks may include but are not limited to:

-Discomfort during and after the insertion of a needle
-"needle sickness" (dizziness, Fainting, Nausea)
-Localized, minor burns with the use of Moxa
-Possible, temporary aggravation of symptoms that existed prior to treatment
-Possible risk of spontaneous miscarriage (extremely rare)
-A broken needle (rare with the use of disposable needles)
-Pneumothorax, organ puncture (extremely rare)

Please notify your practitioner if you have any adverse effects from treatment

Special situations: Some acupuncture points are contra-indicated during pregnancy. Please notify us if you night be pregnant. Additionally, please inform us if you have severe bleeding disorders or if you are wearing a pacemaker or other electronic medical device.

Use of disposable needles: To reduce the possibility of infection from acupuncture, all needles are pre-steralized, one-time-use needles made of surgical steel, copper, silver, or gold.

Knowing the above information I consent to treatment

Signed:_____**Date**____/____/____

Cancelation/No Show Policy

Appointments are in high demand.

In order to be respectful to the needs of other clients, please be courteous and call the center promptly if you are unable to keep your appointment.

Your early cancelation will give another person the possibility to have access to timely care.

Appointments not cancelled at least 24 hours in advance, will be charged for the missed appointment.

I have been informed and understand the above policy.

Signed:_____Date____/____/____