



# PRIOUX CHIROPRACTIC

## Acupuncture/Cupping Intake Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: F \_\_\_\_ M \_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone - Cell: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Home: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Marital Status: \_\_\_\_\_ Option – Height: \_\_\_\_\_ Weight: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Have you been treated by Acupuncture or Oriental Medicine before? Y \_\_\_\_ N \_\_\_\_

Name of your Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address of your Physician: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phone (Daytime): (\_\_\_\_)\_\_\_\_-\_\_\_\_ (Evening) (\_\_\_\_)\_\_\_\_-\_\_\_\_

### **Main Complaint and Present Medical History**

1. Main problem you would like us to help you with: \_\_\_\_\_
2. How long ago did this problem begin: \_\_\_\_\_
3. Have you been given a diagnosis for this problem? If so, what? \_\_\_\_\_
4. What kind of treatments have you tried? \_\_\_\_\_
5. Are you currently receiving treatment for your problems? \_\_\_\_\_ If so, please describe: \_\_\_\_\_
6. Does anything improve your problem? \_\_\_\_\_

### **Past Medical History**

Illnesses: \_\_\_\_\_  
\_\_\_\_\_

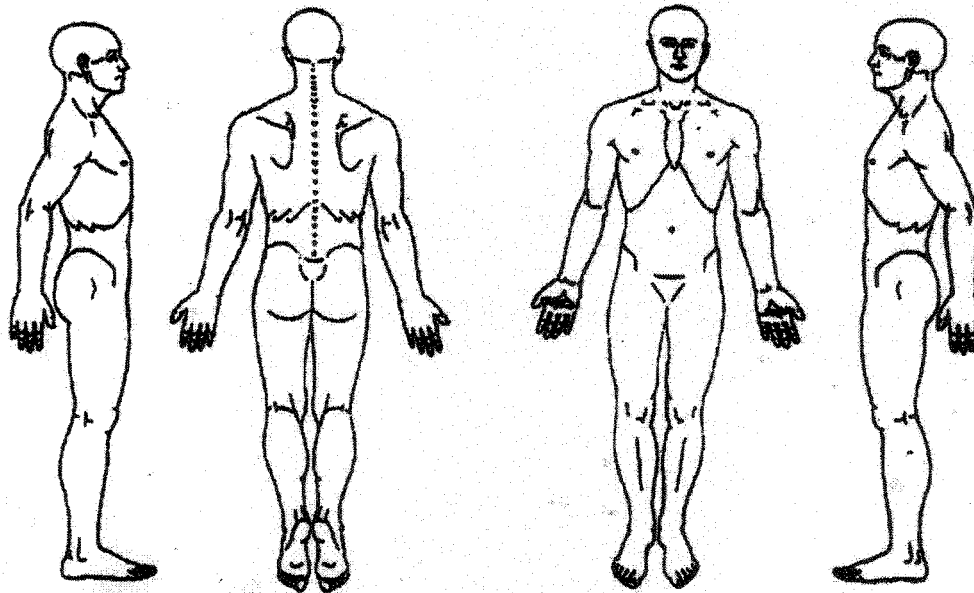
Surgeries: \_\_\_\_\_  
\_\_\_\_\_

Significant trauma (auto accidents, falls, etc.) \_\_\_\_\_

Do you have, or have you ever had, any Infectious Diseases? Y \_\_\_\_ N \_\_\_\_

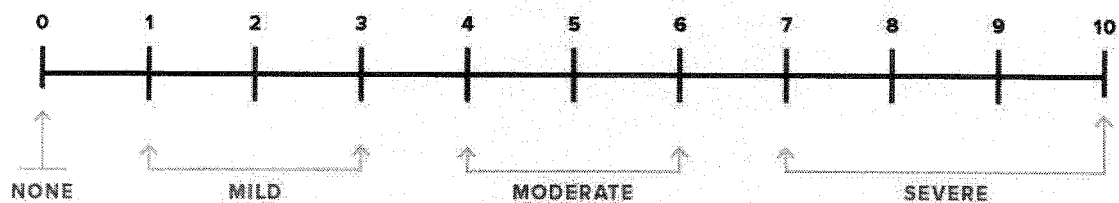
If so, please describe: \_\_\_\_\_

Please circle on the diagram any areas of any type of pain or injury.



Please try to describe the type and quality of the pain: \_\_\_\_\_

Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:



Are there any other internal organ or systemic dysfunctions that we should be aware of? \_\_\_\_\_

Are there any other problems you would like to discuss? \_\_\_\_\_

### **Consent for Acupuncture**

I, undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion, and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on specific illness and their construction. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments.

\_\_\_\_\_  
Patient's Signature (Parent or Guardian if Under 18)

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