

Name: _____ Date: ____/____/____
(first) (middle) (last)

Date of Birth: ____/____/____ Marital status: Single Married Divorced Widow Partner

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____ Emergency contact: _____ Phone: _____

When, where and for what reason did you last receive health care? _____

How did you hear about this clinic? _____

If you have **INSURANCE**:

Health Insurance Company: _____ ID#: _____

Primary insured: _____ Date of Birth: _____ Employer: _____

In order of importance, please list **YOUR HEALTH CONCERNS** bringing you to this clinic:

1. _____
2. _____
3. _____

What are your health goals? _____

I am interested in: Pain Relief Preventive Care Nutritional Advice Maintenance Care Stress Relief
 Herbal Therapy Other: _____

ALLERGIES (foods, drugs, or medications): _____

MEDICATIONS (prescribed and over-the-counter), vitamins, and supplements currently taking: _____

Do you have any reason to believe you may be *pregnant*? Y N

Do you have any *infectious diseases*? Y N If yes, please explain: _____

Do you have any *chronic illness*? Y N If yes, please explain: _____

HEIGHT: _____ **WEIGHT:** Currently: _____ Past Maximum: _____ Ideal Weight: _____

BLOOD PRESSURE: ____/____ Date taken? _____

FAMILY HISTORY (father, mother, siblings):

Cancer Diabetes Heart Disease High Blood Pressure Stroke Mental Illness

HOSPITALIZATIONS AND SURGERIES (Reason & When): _____

X-RAYS/CAT SCANS, MRI's, SPECIAL STUDIES (Reason & When): _____

FEMALE CONCERNS:

Is your cycle regular? Y N Is your cycle painful: Y N Birth Control Type: _____

of Pregnancies: _____ # of Births: _____ PMS Clotting Discharge Other concern

ANYTHING ELSE we should know? _____

Do you typically eat at least three meals per day? Y N If not, how many? _____

Typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Liquid consumption: How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Exercise routine: _____

Relaxation practice: _____

Sleep: How many hours per night do you sleep? _____ Do you wake rested? Y N

Education: _____

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y N Why/Why not? _____

Nicotine/Alcohol/Caffeine use: _____

Traumas: Have you experienced any major traumas (physical, emotional, sexual)? Y N Explain: _____

Interests and hobbies: _____

Habits: Television: _____ Reading: _____ Other: _____

YOUR BODY:

- Mood Swings
- Nervousness
- Mental Tension
- Fatigue
- Slow Healing
- Chronic Infection
- Chronic Fatigue S.
- Vision Problems
- Eye Pain/Strain
- Glasses/Contacts
- Tearing/Dryness
- Hearing Problems
- Ear Ringing
- Earaches
- Headaches
- Sinus Problems
- Nose Bleeds
- Freq. Sore Throats
- Teeth Grinding
- Jaw Problems
- Hay Fever
- Frequent Colds
- Difficult Breathing
- Emphysema
- Pneumonia
- Persistent Cough
- Asthma
- Tuberculosis
- Shortness of Breath
- Heart Disease
- Chest Pain
- Swollen Ankles
- Blood Pressure
- Palpitations
- Stroke
- Heart Murmurs
- Rheumatic Fever
- Varicose Veins
- Ulcers
- Appetite Change
- Nausea/Vomiting
- Epigastric Pain
- Excessive Gas
- Heartburn
- Kidney Disease
- Painful Urination
- Frequent UTI
- Frequent Urination
- Belching
- Venereal Disease
- Kidney Stones
- Gall Bladder problem
- Liver Disease
- Hepatitis B or C
- Hemorrhoids
- Abdominal Pain
- Impaired Urination
- Blood in Urine
- Night Urination
- Irregular Menses
- Breast Lumps/Pain
- Nipple Discharge
- Heavy Flow
- Vaginal Discharge
- Frequent Bleeding
- Menopausal
- Fertility problem
- Painful Periods

Consent to Treatment Form

By signing below, I voluntarily consent to be treated with acupuncture, electro-acupuncture, herbs, heat, and massage by Lisa Thorborg, L.Ac., at Aasa-Lisa's Acupuncture. I understand that I may refuse any of the therapies.

I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction and pain, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

If herbs are recommended, I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand the above information. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

