

Rooted Community Acupuncture Intake Form

Name \_\_\_\_\_ DOB \_\_\_\_\_

Full Address \_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact Name and Number \_\_\_\_\_

Have you had acupuncture before? \_\_\_\_\_ How did you hear about our clinic? \_\_\_\_\_

**\*\*\*Please list all medications, supplements, and surgeries on the back of this page.\*\*\***

What is your **primary** reason for coming for acupuncture? \_\_\_\_\_

How long have you had this issue? \_\_\_\_\_ Rate your pain / discomfort on a scale of 1 to 10: \_\_\_\_\_

What is your **secondary** reason for coming for acupuncture? \_\_\_\_\_

How long have you had this issue? \_\_\_\_\_ Rate your pain / discomfort on a scale of 1 to 10: \_\_\_\_\_

**\*\*\*Please list all medications, supplements, and surgeries on the back of this page.\*\*\***

**Please mark all symptoms that apply.**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> hypertension                            | <input type="checkbox"/> high stress                | <input type="checkbox"/> frequent urination      | <input type="checkbox"/> phlegm in throat            |
| <input type="checkbox"/> hypotension                             | <input type="checkbox"/> anger/frustration          | <input type="checkbox"/> generalized muscle pain | <input type="checkbox"/> chronic cough               |
| <input type="checkbox"/> high cholesterol                        | <input type="checkbox"/> sadness                    | <input type="checkbox"/> generalized joint pain  | <input type="checkbox"/> shortness of breath         |
| <input type="checkbox"/> hypothyroid                             | <input type="checkbox"/> worry/overthinking/anxiety | <input type="checkbox"/> heaviness in the limbs  | <input type="checkbox"/> dry or watery eyes (circle) |
| <input type="checkbox"/> hyperthyroid                            | <input type="checkbox"/> excessive fear             | <input type="checkbox"/> headaches/migraines     | <input type="checkbox"/> premature ejaculation       |
| <input type="checkbox"/> diabetes                                | <input type="checkbox"/> forgetfulness/distracted   | <input type="checkbox"/> neck pain               | <input type="checkbox"/> impotence                   |
| <input type="checkbox"/> sleep apnea                             | <input type="checkbox"/> hot flashes/night sweats   | <input type="checkbox"/> shoulder pain           | <input type="checkbox"/> severe PMS                  |
| <input type="checkbox"/> asthma                                  | <input type="checkbox"/> excessive sweating         | <input type="checkbox"/> arm pain                | <input type="checkbox"/> heavy menstrual bleeding    |
| <input type="checkbox"/> osteoarthritis                          | <input type="checkbox"/> cold hands/feet            | <input type="checkbox"/> elbow pain              | <input type="checkbox"/> irregular menstrual cycle   |
| <input type="checkbox"/> rheumatoid arthritis                    | <input type="checkbox"/> often cold                 | <input type="checkbox"/> hand/finger pain        | <input type="checkbox"/> cramping                    |
| <input type="checkbox"/> fibromyalgia                            | <input type="checkbox"/> often hot                  | <input type="checkbox"/> low back pain           | <input type="checkbox"/> clotting                    |
| <input type="checkbox"/> celiac disease                          | <input type="checkbox"/> trouble falling asleep     | <input type="checkbox"/> mid back pain           | <input type="checkbox"/> menopausal                  |
| <input type="checkbox"/> hysterectomy                            | <input type="checkbox"/> trouble staying asleep     | <input type="checkbox"/> upper back pain         | <input type="checkbox"/> postmenopausal              |
| <input type="checkbox"/> Parkinson's                             | <input type="checkbox"/> fatigue during the day     | <input type="checkbox"/> hip pain                | <input type="checkbox"/> pregnant                    |
| <input type="checkbox"/> stroke                                  | <input type="checkbox"/> acid reflux/heartburn      | <input type="checkbox"/> leg pain                | _____ oz water per day                               |
| <input type="checkbox"/> IBS                                     | <input type="checkbox"/> nausea                     | <input type="checkbox"/> knee pain               | smokes: _____ per day                                |
| <input type="checkbox"/> shingles                                | <input type="checkbox"/> vomiting                   | <input type="checkbox"/> foot/toe pain           | alcohol: _____ per day                               |
| <input type="checkbox"/> cancer _____                            | <input type="checkbox"/> bloating                   | <input type="checkbox"/> chronic runny nose      |  |
| <input type="checkbox"/> skin condition _____                    | <input type="checkbox"/> constipation               | <input type="checkbox"/> chronic congestion      |  |
| <input type="checkbox"/> other diagnosed medical condition _____ | <input type="checkbox"/> diarrhea                   | <input type="checkbox"/> seasonal allergies      |  |
|  | <input type="checkbox"/> painful urination          | <input type="checkbox"/> food allergies          |  |

**Informed Consent and Financial Policy** I hereby request and consent to the performance of acupuncture or other modalities within the scope of practice of Oriental Medicine on me by Saja Lynn, L.Ac., who is licensed in Florida to practice acupuncture. I understand that there are some risks to treatment, including but not limited to some bruising and/or slight bleeding, some pain at the site of the needle insertion, dizziness or fainting, or possible aggravation of existing symptoms. The risk infection is very slight, as all needles used are sterilized, single-use, and disposable. I have had the opportunity to discuss with Saja Lynn, L.Ac., the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect Saja Lynn, L.Ac., to be able to anticipate and explain all outcomes and risks. I understand that I may stop treatments at any time. I understand that the evaluation given to me is an assessment based on the theories of East Asian Medicine. I understand that Saja Lynn, L.Ac., is not providing Western medical care, and that I should look to my primary care practitioner for those services. Payment is expected at the time of treatment. The cost of an acupuncture treatment is payable on a sliding scale of \$15.00-\$35.00, plus a one-time fee of \$10.00 due at the first visit. Unless canceled at least 4 hours in advance, our policy is to charge \$10.00 for missed appointments. I have read the above consent and financial policy. I have had the opportunity to ask questions, and by signing I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_