Acupuncture Intake Form

Welcome to the office of Laura Loterszpil. Chinese Medical Diagnosis requires complete and honest answers to questions pertaining to both the body and the spiritual/ emotional state as well. Thank you for taking the time to fill out this form completely.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name____________________________________Date of Birth____________________

Address______________________City______________State_________Zip__________

Day Phone______________Evening Phone_________________Cell________________

e-mail address____

How did you hear about Laura Loterszpil?
Google ___ Yahoo ___ City Search___ Dex Online ___
Other Online Search or Online Yellow Pages ________ Dex Yellow Pages__________
Yellow Book Yellow Pages___ Verizon Yellow Pages____ Other__________________

In case of emergency contact____

Address (if different from above)____

Phone________________________ Relationship_______________________________

Please describe the reason for your visit today (Chief Complaint)___________________

____

Is it getting better, worse, or staying the same?__________________________________

____

Are you, or have you been, treated for this problem with any other health professionals?
____

Has it been effective?____

What was your diagnosis?____

Are you taking any medication or herbal supplements? If so, which ones? (Add dosage if known)

Are you in generally good health, or do you frequently fall ill?

What illnesses might you be prone to? (ie, frequent colds, Gastro-intestinal problems)

MEDICAL HISTORY

Please circle any current health issue. For those diseases which are part of your health history, please note the year of the occurrence.

Allergies	Epilepsy	Polio
Anemia	Fatigue	Scarlet Fever
Appendicitis	Gout	Stroke
Arteriosclerosis	Heart Disease	Surgery (List):
Asthma	Hepatitis (A, B,C)	___________________
Bleeding Disorder	Hypoglycemia	___________________
Blood Pressure (Low or High)	Injuries	___________________
Cancer	Insomnia	Thyroid Disorder
Chicken Pox	Intestinal Parasites	Trauma (falls,
accidents)		
Diabetes	Multiple Sclerosis	Tuberculosis
Digestive Disorders	Mumps	Ulcers
Emotional Difficulties	Pacemaker	
Other_________________		
Emphysema	Weight Loss or Gain	
______________________		

Do any of your family members suffer from: (Please list relationship to you)

Alcoholism	Arteriosclerosis	Heart Disease
Allergies (list)	Asthma	High Blood Pressure
______________	Cancer	Seizures
______________	Diabetes	Stroke

Which of the following are part of your lifestyle? How frequently do you engage in it?

Alcohol	Nicotine	Exercise
Coffee	Recreational Drug Use	Excessive Sugar

Do you usually eat three meals a day? ________Do you follow any particular diet?_____

On the scale of 1-10, how would you rate the level of stress in your life currently?

What is the level of stress in your life in general (1-10)?

How does stress affect you? (ie, more headaches, stomach pain, etc.)

____

Are there any other concerns you would like to address?

____

____

REVIEW OF SYSTEMS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! Place **one check** next to a symptom you have experienced, **two checks** next to a frequently occurring symptom, and **three checks** next to a symptom that is particularly distressing to you.

Head and Face
Headaches
Dizziness
Memory Loss
Other

Eyes
Blurry Vision
Eyelid Twitching
Floaters
Pain

Nose
Frequent Colds
Sinus Trouble
Bleeding

Mouth
Dental Problems
Gum Problems
Teeth Grinding/TMJ
Unusual Tastes
Other

Throat
Sore Throat
Hoarseness
Difficulty Swallowing
Dryness
Other

Heart and Chest
High Blood Pressure
Low Blood Pressure
Chest Pain
Chest Tightness
Difficulty Lying Down
Other

Circulation
Easy Bruising
Easy Bleeding
Cold Limbs-Hands or Feet
Reynaud's Syndrome

Gastrointestinal
Always Thirsty
Never Thirsty
Excessive Appetite
Low Appetite
Gas/Bloating
Stomach or Abdominal Pain
Nausea
Diarrhea/Loose Stools
Constipation
Rectal Bleeding
Colon Problems

Urination
Frequent
Difficult

Skin
Acne
Dryness
Moles that Change
Lumps
Excessive Sweating
Night Sweats
Rarely Sweat
Other

Neurological
Nervousness/Anxiety
Tremors
Numbness or Tingling
Lack of Coordination
Nerve Pain
Other

Sleep
Insomnia
Drowsiness
Excessive Dreaming
Waking Easily
Other

Pain - Please Describe
____
____
____
____

Respiration
Difficulty Inhaling
Difficulty Exhaling
Pain
Cough
Congestion
Shortness of Breath
Other

Painful
Nocturnal
Bleeding
Other

Are there any other health concerns you'd like to address?
____
____

WOMEN ONLY

Are you, or could you be pregnant?_______________ If so, how far along?_____________

Number of pregnancies______ Births_________ Abortions_____Miscarriages___________

What form of birth control do you use?____

Do you have regular PAP smears?_______________ How Often? ____________________

Age of first menses__________ Age of menopause, if applicable_____________________

Do you bleed between periods?_________ Do you bleed after intercourse?_____________

Have you ever had any gynecological surgeries or any abnormal findings on any tests?__

____

Are your periods uncomfortable or painful, either emotionally or physically?__________

Are your periods:

Short (Less than 28 days)______Long (28+ days)______Varied______ Regular_______

Painful? If so, Before_________ During_________ After_________

Do you bleed heavily_________? Lightly_________? Very little?__________

Do you have clots ?_______ Early in the cycle_______ or throughout?__________

Relative to the blood that comes from a wound, is your menstrual blood: The same color________More pale_______ Purple_______ More Red_______ More Brown_____

How many days do you bleed?___________

Do you have any of the following Pre-Menstrual Symptoms? (Emotions are not judged in Chinese Medicine, they are neither good nor bad. They are, however, important diagnostic tools. Please answer honestly.)

Irritability____ Depression______ Crying______ Rage______ Nausea_________

Cravings, and if so for what?______________Breast Tenderness______________

Any other symptoms around the time of your period?________________________

____

Are you experiencing any low or high sexual desires?_________ Do you have any concerns surrounding this?____

Do you have any other gynecological concerns or complaints?__________________

____

____

____

____

MEN ONLY

Do you experience any of the following:

Reduced Libido________ Excessive Libido_________ Impotence_____________

Urinary Frequency_______ Premature Ejaculation__________ Discharge________

Genital/ Testicular pain___________

Any other concerns?____

I have provided correct and complete information to the best of my knowledge.

____________________________________ ______________________

Patient's or Guardian's signature Date

PATIENT'S RIGHTS

- -The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known
- -The patient may seek a second opinion from another health care professional or may terminate therapy at any time.
- -In a Professional Relationship, sexual intimacy is never appropriate and should be immediately reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of Acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1340, Denver, CO. 80202. Tel (303) 894-7851.

I have read and understand this document

________________________________ ___________________
Patient's or Guardian's signature Date

STATEMENT OF INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by Laura Loterszpil Lic. Ac., representing Laura Loterszpil , on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible).

I understand that there are minor risks associated with acupuncture treatment, including, but not limited to, slight bleeding and/or bruising of the skin. I understand that the risk of infection is negligible when using single use, disposable needles.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise good judgment during the course of the procedure, based on the facts then know, and act in my best interest.

I have read the above consent, or have had it read to me. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

Following your treatment:

1) Occasionally, a person may feel light headed after an acupuncture treatment. If this happens to you, please sit for a while in the designated area. You'll feel fine in a few minutes.
2) Herbs prescribed for the patient are intended for his or her use only, and should not be used by those for whom they are not dispensed.

PAYMENT WILL BE REQUESTED FOR CHANGES OR CANCELLATIONS OF LESS THAN 24 HOURS

Please sign and date below to indicate that you have read and understand this form.

____ ___________________
Patient Signature (or Guardian, if minor) Date

____
Printed Name

Address City, State, Zip

Phone (Daytime) (Evening)

Laura Loterszpil
Licensed Acupuncturist
14300 Gallant Fox Lane suit 202, Bowie MD 20715