CAROLINASCHIROPRACTIC
AND SPINAL REHAB

Acupuncture Intake Form

Name:__________________________________ **Date of Birth:**______________**Today's Date:**______________

Have you had Acupuncture before? ____Yes ____No **If yes, for which area and how long ago?**

____

Current main problem(s):____

What diagnosis, if any, have you received for this problem? ________________________________

What kind of treatment/s have you tried? ____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Allergies: (drugs, chemicals, foods, environmental):____

Medications: (taken within the last two months, including vitamins, OTC drugs, herbs, etc., and their dosages):____

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

Poor appetite		Poor sleep		Fatigue		Fevers		Chills	
Night sweats		Sweat easily		Tremors		Poor balance		Bleed or bruise easily	
Weight loss		Weight gain		Pain		Ear aches		Spots in front of eyes	
Ringing in ears		Poor hearing		Sore throat		Sinus problems		High blood pressure	
Chest Pain		Palpitations		Fainting		Irregular heartbeat		Low blood pressure	
Cough		Wheezing		Bronchitis		Pneumonia		Nausea	
Vomiting		Diarrhea		Gas		Constipation		Depression	
Anxiety		Stress		Bi-polar		Bad temper		Kidney stones	
Painful urination		Blood in urine		Itching		STD		Frequent urination	
Ulcerations		Hives		Eczema		Acne		Urgency to urinate	
Rashes		Weight loss		Weight gain		Pregnancy		Varicose veins	

Female (Check all that apply):

Clots or Fibroids		Vaginal/genital discharge		Ovarian cysts	
Breast Lumps		Pain/cramps prior/during periods		Breast tenderness	
Hot flashes		Moodiness related to periods		Irregular periods	
Endometriosis		Frequent vaginal infections		Pelvic infection	

First date of last period: _______________ Age of first period:______
Duration of periods _______days, cycle ______ days
Do you use birth control ? ___Yes ___No. If yes, what type and for how long? ______________________

Male (Check all that apply):

Prostate problems		Discharge		Erectile dysfunction	
Ejaculation problems		Frequent seminal emission		Fertility problems	
Painful/swollen testicles		Other: _______________			

I hereby request and consent to the performance of acupuncture treatments and other procedure within the scope of practice on me (or on the patient named below, for whom I am legally responsible) by Dr. Matthew Budavich and/or other providers who practice acupuncture now or in the future at Carolinas Chiropractic and Spinal Rehab.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including: bruising, numbness or tingling near the needle sites that may last a few days and dizziness or fainting. Unusual risks of acupuncture include: spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pnuemothorax). Infection is another possible risk, although sterile disposable needles are used with all patients to maintain the safest and most sterile treatment environment possible. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I will notify a clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest.

I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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:**____________________

Doctor's Signature:____________________