Acupuncture Intake Form – Pregnancy

Today's date___________________

Name: ___________________________________ Age _________DOB_____________ Date of last menstrual period ___________________

Street Address: ____

City, Zip: ____

Best contact phone # _________________________ Email ____

Any current health concerns?____

Have you had acupuncture before? (Yes/No) When was your last treatment? ___________What is your blood type? (A, B, AB, O, or unknown)

Other therapies you are currently receiving? ____

Current medications and supplements? ____

General History:

❑ Abnormal Pap Smears	❑ Fertility Issues	❑ Pace Maker Pelvic Inflammatory Disease
❑ Allergies	❑ Fibroids/ Polyps/ Myomas	❑ Scarlet Fever
❑ Anemia	❑ Heart Disease	❑ Sexually Transmitted Diseases
❑ Arthritis	❑ Hepatitis	❑ Skin Cancer
❑ Asthma	❑ Herpes HIV/ AIDS	❑ Thyroid Disorders
❑ Autoimmune Disease	❑ High Blood Pressure	❑ Tuberculosis
❑ Diabetes Mellitus	❑ Low Blood Pressure	❑ Urinary Incontinence
❑ Elevated Cholesterol	❑ Osteoporosis	❑ Other
❑ Endometriosis	❑ Other Cancers	

Family History:

❑ Alcoholism	Diabetes	Ovarian Cancers
Autoimmune Diseases	Endometriosis/ Fibroids	Osteoporosis
Breast Cancers	Fertility Issues	Other Cancers ______________
DES Usage	Hysterectomy	Thyroid Conditions

Reproductive History

Is this your 1st pregnancy? _________ If no, how many total pregnancies? ______ # of pregnancies carried to term?_____

# of pre-term pregnancies? _______ # of abortions? ______# of miscarriages? _____ How many living children?_______ Ages:____________

Before pregnancy, how was your period? Regular? (~28 days) __________ Days of Flow? ________ Pain? ____________ PMS? _________

At what age did you begin your menstruation? □ < 11 □ 11 □12-14 □15 □ >15

***WHEN COMPLETING INFO BELOW: □ □ Check 1st box if you experienced before pregnancy, 2nd box- during pregnancy

General Symptoms

□ □ Poor appetite
□ □ Heavy appetite
□ □ Strongly like cold drinks
□ □ Strongly like hot drinks
□ □ Peculiar taste
□ □ Cravings
□ □ Sweats easily
□ □ Night sweats
□ □ Poor sleep
□ □ Dream disturbed sleep
□ □ Heavy sleep
□ □ Bodily heaviness
□ □ Chills
□ □ Fever
□ □ Bleed or bruise easily
□ □ Cold hands or feet
□ □ Poor circulation
□ □ Vertigo or dizziness
□ □ Fatigue
□ □ Lack of strength
□ □ Shortness of breath
□ □ Muscle cramps

Head, Eyes, Ears, Nose, Throat

□ □ Headaches
□ □ Migraines
□ □ Facial pain
□ □ Glasses
□ □ Poor vision
□ □ Blurred vision
□ □ Eye strain
□ □ Red eyes
□ □ Itchy eyes
□ □ Spots in eyes
□ Glaucoma
□ □ Night Blindness
□ □ Sores on lips or tongue
□ □ Swollen glands
□ □ Dry mouth
□ □ Excessive saliva
□ □ Recurrent sore throat
□ □ Lumps in throat
□ □ TMJ
□ □ Teeth problems
□ □ Grinding teeth
□ □ Sinus problems
□ □ Enlarged thyroid
□ □ Excessive phlegm
□ □ Earaches
□ □ Ringing in ears
□ □ Poor hearing
□ □ Gum problems

Respiratory

□ □ Difficulty breathing when lying down
□ □ Shortness of breath
□ □ Tight chest
□ □ Cough Wet or dry?
□ □ Color of phlegm
____
□ □ Coughing blood
□ □ Asthma/ wheezing
□ □ Pneumonia

Cardiovascular

□ □ High Blood Pressure
□ □ Tight chest
□ □ Blood clots
□ □ Fainting
□ □ Difficulty breathing
□ □ Heart palpitations
□ □ Irregular heart beat

Gastrointestinal

Bowel movements:
Frequency:________________________
Texture/Form______________________
Color:____________________________
Odor______________________________
□ □ Diarrhea
□ □ Constipation
□ □ Laxative use
□ □ Mucous in stools
□ □ Itchy anus
□ □ Anal fissures
□ □ Black stools
□ □ Bloody stools
□ □ Gas
□ □ Bloating
□ □ Intestinal pain or cramping
□ □ Burning anus
□ □ Rectal pain
□ □ Hemorrhoids
□ □ Nausea
□ □ Vomiting
□ □ Acid regurgitation
□ □ Bad breath
□ □ Hiccup

Musculoskeletal

□ □ Joint pain
□ □ Muscle pain
□ □ Neck/ shoulder pain
□ □ Upper back pain
□ □ Lower back pain
□ □ Rib pain
□ □ Limited range of motion
□ □ Limited use

Skin and Hair

□ □ Rashes
□ □ Eczema
□ □ Dandruff
□ □ Hair loss
□ □ Change in hair / skin texture
□ □ Hives
□ □ Psoriasis
□ □ Itching
□ □ Fungal infections
□ □ Ulcerations
□ □ Acne

Neuropsychological

□ □ Seizures
□ □ Poor Memory
□ □ Irritability
□ □ Considered/ attempted suicide
□ □ Numbness
□ □ Depression
□ □ Easily stressed
□ □ Tics
□ □ Anxiety
□ □ Abuse survivor
□ □ Kidney stone

Genito-urinary

□ □ Pain when urinating
□ □ Blood in urine
□ □ Venereal disease
□ □ Increased libido
□ □ Impotence
□ □ Frequent urination
□ □ Bedwetting
□ □ Unable to hold urine
□ □ Decreased libido
□ □ Premature ejaculation
□ □ Wake to urinate
□ □ Incomplete urination
□ □ Kidney stone
□ □ Nocturnal emission

Your Diet

Appetite □ Low Strong Too Busy to Notice
□ □ Coffee (#/day)___
□ □ Sugar
□ □ Salty food
□ □ Soft Drinks
□ □ Artificial sweeteners
□ □ Processed/Packaged foods?
□ □ Thirst for water: ________
□ □ # of glasses per day______
□ □ meat (#/wk)
____
□ □ dairy (#/wk)
____

Yesterday's Breakfast ____ Lunch____

Dinner____Snacks__________________________________Is this a typical day? Y or N

Your Lifestyle

□ □ Alcohol
□ □ Tobacco
□ □ Drugs
□ □ Marijuana
□ □ Stress
□ □ Occupational Hazards
□ □ Regular Exercise: Type____ Frequency:________________

Office Policies and Procedures

12655 Washington Blvd. Suite 106 Los Angeles, CA 90066 310.943.9044

Patient's Name: ____

Informed Consent

Acupuncture is an ancient healing art, recognized and relied on its simplicity and effectiveness for thousands of years. The statements listed below will assist your understanding and participation in the treatment process.

- Acupuncture is a technique utilizing tiny stainless steel needles inserted at specific points in the body in order to correct various ailments and stimulate the flow of vital energy. The location and depth of their insertion is determined by the nature of the patient's condition. I understand that the application of these needles may be accompanied by some painful sensations, and the rare possibility of bruising. From the standpoint of Oriental Medicine, these indications are not incompatible with effective treatment.
- Acupuncture therapy also includes the use of indirectly applying heat supplied by the burning of the herb Folium Artimesiae Vulgaris, commonly known as Mugwort. This process is known as "moxibustion."
- On rare occasions, patients have experienced faintness or nausea during an acupuncture treatment. This can be easily remedied and I will advise the Acupuncturist of these sensations.
- Acupuncture is not advised when the patient is too hungry, too full, or under the influence of drugs and/or alcohol. I understand that it is my responsibility to advise the Acupuncturist of these circumstances.

Initial ____________________

Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Payment and Insurance

- Payment for treatment is expected after services are rendered. Payment and/or pre-payment of service is non-refundable regardless of treatment outcome.
- I will be provided with a super bill upon my request; it is my responsibility to submit this to my insurance, and complete any necessary follow-up with the insurance company for reimbursement.

Initial ____________________

Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Cancellation Policy

I understand that I am expected to keep all my appointments as scheduled in order to ensure maximum progress in my, or my child's, treatment. I understand that the practitioner's time is reserved exclusively for my, or my child's, care for the duration of all scheduled visits, and that if I am late for my visit, the visit will end at the scheduled time and I will still be charged for the full visit time. If for some reason I cannot make an appointment, I will call at least **2 business days in advance** to cancel or reschedule that visit. I understand that if I cancel an appointment **less than 2 business days** prior to the scheduled time, I will be charged a fee that represents 50% of the cost of my scheduled appointment. I further understand that if I cancel **less than 1 business day** before my appointment, or fail to show for my appointment, I will be charged a fee that represents the full cost of my scheduled appointment.

Initial ____________________

Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Authorization for Payment
I hereby authorize Emily Bartlett to charge my account balance to the credit card indicated below. I authorize this credit card to be used as a guarantee against late cancellations and missed appointments, and for any and all balances including those relating to office visits, telephone/e-mail consultations, missed/late appointments, miscellaneous fees, and charges for nutritional supplements. I agree that if my credit card does not accept the charge, I will immediately make payment to Emily Bartlett for the amount due. I understand that I may cancel this authorization in writing at any time.

Visa/MC (circle type) #: ___________________________________Exp Date:___________ **Security Code:_______**

Authorized signature:____

Telephone/E-mail Policy

I understand that extended telephone consultations over 10 minutes, will be billed at the same consultation rate as in-person visits and charged to my credit card on file.
I further understand that e-mails which take over 10 minutes to read and reply will be billed at the in-person consultation rate and charged to my credit card on file. By sending an e-mail, I acknowledge and agree that a prompt reply is NOT required, expected, or contemplated. I acknowledge that I will not use e-mail communication to deal with emergencies or other time-sensitive issues. I understand that e-mail communications may not be secure and that there is some possibility that confidentiality of such communications may be breached by a third party. I understand that Emily Bartlett/Holistic Kid may keep copies of e-mail communications and that such messages may be included in your, or your child's, medical record.

Initial ________________
Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Notice of Privacy Practices

Questions and Complaints
If you have any questions about the Notice of Privacy Practices, please contact:
Emily Bartlett Acupuncture: Privacy Officer, 126655 Washington Blvd. Suite 106 Los Angeles, CA 90066
If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way should you choose to file a complaint.

Initial ________________
Please initial here and sign the last page to acknowledge that you have received, reviewed, and agree to the Notice of Privacy Practices. If patient is a minor, both parents and/or all legal guardians must initial and sign.

I have read and understand all of the contents in this document and agree to all of the terms listed above.

Printed Name:____ Date:__________________

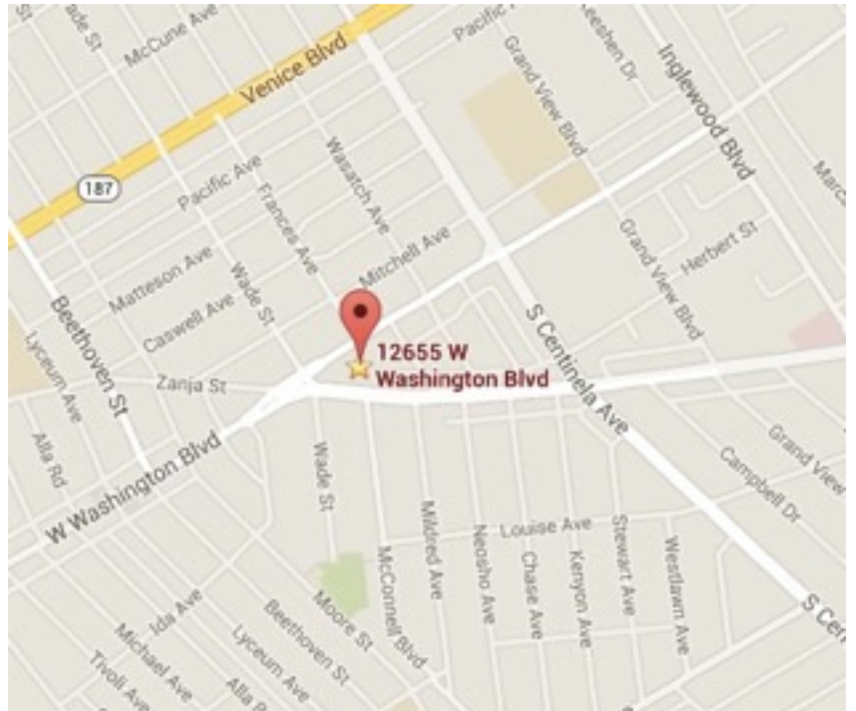
Signature____ Date:___________________

Directions and Parking

Our office is located at 12655 Washington Blvd 90066 Suite 106, near the intersection of Washington Blvd and Washington Place.

PARKING: Please park in a space marked 106 or 104. If there are no spots open, there is ample street parking on Washington Place.

If lost or late, please call us:
310-943.9044.



From the beach taking 10E - Exit Centinela, Turn left onto Pico Blvd, Take 3rd right onto S. Bundy Drive which turns into Centinela Ave. (2.6 miles) to W. Washington **Blvd**. Turn right on W. Washington **Blvd**. The office a a dark brown building on your right.

Taking 10W - Exit Bundy Drive South, continue on S. Centinela Ave (2.6 miles) to W. Washington **Blvd**. Turn right on W. Washington **Blvd**. The office is a dark brown building on your right.

Taking 405S - Exit Venice Blvd. Turn left on Sawtelle - go 0.2 miles, Right onto Washington Place - go about one mile. The office is a dark brown building on your left.

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Taking 405N - Exit CA-90W toward Marina del Rey. Go 1.1 miles and take the Centinela exit. Turn right on S. Centinela Ave. Go 1.1 miles and then turn left onto W. Washington Blvd. The office is a dark brown building on your left.

PARKING: Please park in a space marked 106 or 104. If there are no spots open, there is ample street parking on Washington Place.

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