Dr. Leslie Deems, DACM, L.Ac.
Functional Family Medicine
leslie@awakenbalance.com
(510) 846-8451

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

Address: _____ City: _____ State: ___ Zip: _____

Phone #: _____ Email: _____ Referred by: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F

In case of emergency, contact: _____ Phone #: _____

Who is your Primary Care Physician? _____ Phone #: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Have you ever had acupuncture before? Yes No Do you have a pace maker? Yes No

Do you have any surgical implants? Yes No Are you pregnant? Yes No

Height: _____ **Weight:** _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____

When was this reading taken? _____

Are you presently taking any medication, herbs, homeopathic remedies, supplements? Yes No

Please list: _____

_____

_____

Please list any allergies that you may have (drugs, food, chemicals): _____

_____

_____

When and where did you last receive health care? _____

For what reason? _____

Condition:

Please identify the health concerns that have brought you to this clinic in order of importance below:

Chief Complaint (1) _____

Date of Onset:____/___/_____ Is your condition: □ Getting Worse □ Constant □ Intermittent

How does this condition affect you?_____

What makes it better? _____ What makes it worse? _____

Do you have a western medical diagnosis for this condition? Y/N _____ Level of

Pain on a scale of 1-10 (10 being severe pain): _____

2)_____

Date of Onset:____/___/_____ Is your condition: □ Getting Worse □ Constant □ Intermittent

How does this condition affect you?_____

What makes it better? _____ What makes it worse? _____

Do you have a western medical diagnosis for this condition? Y/N _____ Level of

Pain on a scale of 1-10 (10 being severe pain): _____

3)_____

Date of Onset:____/___/_____ Is your condition: □ Getting Worse □ Constant □ Intermittent

How does this condition affect you?_____

What makes it better? _____ What makes it worse? _____

Do you have a western medical diagnosis for this condition? Y/N _____

Level of Pain on a scale of 1-10 (10 being severe pain): _____

Is there anything else you would like me to know? _____

_____

_____

_____

History:

Check those applicable:

	You	Family Member		You	Family Member
Anemia	□	□	Fibromyalgia	□	□
Asthma	□	□	Chronic Fatigue Syndrome	□	□
Chicken Pox	□	□	Multiple Chemical Sensitivity	□	□
Cancer	□	□	Candida	□	□
Diabetes	□	□	Irritable Bowel Syndrome	□	□
Epilepsy	□	□	Hyperthyroidism	□	□
Hay fever/Hives	□	□	Hypothyroidism	□	□
Hepatitis	□	□	Prostatitis	□	□
HIV/AIDS	□	□	Kidney Disease	□	□
Heart Disease	□	□	Kidney Stones	□	□
High BP	□	□	Gall Stones	□	□
High Cholesterol	□	□	Mental Illness	□	□
Stroke	□	□	Osteoarthritis	□	□
Pneumonia	□	□	Rheumatoid Arthritis	□	□
Bronchitis	□	□	Scoliosis	□	□
TB	□	□	Bleeding Disorders	□	□
Tumors	□	□	Urinary Tract Infections	□	□
Fibroid Tumors	□	□	Heart Murmur	□	□
Liver Disease	□	□			

Immunizations (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis
Hepatitis B HPV/Gardisil Diphtheria

Others: _____

Hospitalizations and Surgeries:

Reason: _____ Date:___/____/_____

Reason: _____ Date:___/____/_____

Reason: _____ Date:___/____/_____ **X-**

Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason: _____ Date:___/____/_____

Reason: _____ Date:___/____/_____

Reason: _____ Date:___/____/_____

Please check all that apply:

Emotional	**Present**	**Past**		**Present**	**Past**
Mood Swings	□	□	Depression	□	□
Nervousness	□	□	Anxiety	□	□
High Stress	□	□	Sadness	□	□
Trouble falling asleep	□	□	Indecisiveness	□	□
Trouble staying asleep	□	□	Excessive Fear	□	□
Night Sweats	□	□	Easily Startled	□	□
Vivid Dreams	□	□	Heart Palpitations	□	□

ENT	**Present**	**Past**		**Present**	**Past**
Impaired Vision	□	□	Dizziness	□	□
Floaters	□	□	Vertigo	□	□
Glaucoma	□	□	Fainting Spells	□	□
Glasses/Contacts	□	□	Headaches	□	□
Dry/Burning Eyes	□	□	Migraines	□	□
Impaired Hearing	□	□	TMJ	□	□
Ear Ringing	□	□	Neck/Shoulder Tension	□	□

Gastrointestinal	**Present**	**Past**		**Present**	**Past**
Ulcers	□	□	Epigastric Pain	□	□
Belching	□	□	Abdominal Pain	□	□
Heartburn/ GERD	□	□	Poor Appetite	□	□
Nausea/vomiting	□	□	Flatulence	□	□
Constipation/Diarrhea	□	□	Nosebleeds	□	□
Bitter Taste in Mouth	□	□	Hemorrhoids	□	□
Itchy Anus	□	□	Rectal Bleeding	□	□
Bad Breath	□	□			

How often do you have a bowel movement? _____

What is the consistency? Firm/Normal Toothpaste Watery Hard/Difficult to Pass

What do your stools resemble? S Shape Long & Thin Undigested Food Goat Stool

Genito-Urinary	**Present**	**Past**		**Present**	**Past**
Frequent Urination	□	□	Burning Urination	□	□
Painful Urination	□	□	Sexual Dysfunction	□	□
Frequent UTI	□	□	Enlarged Prostate	□	□
Urination at Night	□	□	Testicular Pain	□	□
Blood in Urine	□	□	Abnormal Discharge	□	□
Cloudy Urination	□	□	Low Back Pain	□	□
Urinary Retention	□	□			

List Any STDs: _____

Energy/ Immunity	**Present**	**Past**		**Present**	**Past**
Fatigue	□	□	Allergies	□	□
Slow Wound Healing	□	□	Bruising	□	□
Chronic Infections	□	□	Shortness of Breath	□	□
Muscle Pain/Weakness	□	□	Stiff /Sore Joints	□	□
Frequent Colds/Flus	□	□ (x per yr.)	_____		

Lifestyle

How many hours per night do you sleep? _____ Do you wake feeling rested? Y/N

What is your Exercise Routine? _____

Are you a vegetarian? Y/N Are you a vegan? Y/N How many meals do you eat per day? ____

Occupation: _____ How many hours per week do you work?_____

Do you enjoy your work? Y/N Level of Education Completed? _____

Do you smoke? Y/N How often? _____ Do you drink alcohol? Y/N How often? _____

Caffeine Use? _____ Water Intake? _____

Interests/Hobbies: _____ **For**

Females Only:

How many children do you have?_____ How many children have you given birth to?_____

Abortions?_____ Miscarriages?_____Adoptions?_____Age of first menses?_____

Have you ever taken birth control pills? Y/N If yes, for how long? _____

How many days is your cycle? _____ How many days do you bleed? _____

Please describe your menstruation: Amount of flow (heavy, light), color, consistency (clots), cramps.

Day 1_____ Day 5_____ Day

2_____ Day 6_____

Day 3_____ Day 7_____

Day 4_____ Day 8_____

What was the first day of your last menstrual period? ____/____/_____ Do you

suffer from any of the following?

Breast Tenderness? Y/N Pre-Menstrual Cramping / Low back pain? Y/N Mood swings?

Y/N Spotting between Menses? Y/N

For Menopausal Women:

How old were you when you started menopause? ____ Are you still having periods? _____ Do you

suffer from any of the following?

Hot flashes? Y/N If yes, how often? _____ Night sweats? Y/N If yes, how often? _____

Vaginal Dryness? Y/N Mood swings? Y/N Mental Fogginess / Forgetfulness? _____

Treatment Information

Pre-Treatment Considerations: Please eat an adequate amount of food before your treatment. You should not receive acupuncture with an empty or overly full stomach.

Post-Treatment Care: If you receive treatments for pain, avoid aggravation of the painful area between treatments. It is recommended to "baby" that area and avoid strenuous or aggravating activity as much as possible. Following your treatment, your body will make adjustments for up to 36 hours. There is a 10% chance that you may experience an aggravation of the condition that you are being treated for. There is no cause for concern, as this is a healing response to the effective and unique treatment employed. The pain/discomfort and usually subsides within 36 to 48 hours. Typically, the pain will then subside to a lower level than before the treatment.

Treatment Progression and Recovery: Acupuncture treatments stimulate your body's own healing capacity. Therefore, the progress of your healing will follow a natural course. As this occurs, you are likely to experience a reoccurrence of the pain/condition in between your treatments to some degree. The degree of pain, if not aggravated, progressively decreases over a series of treatments. Finally, the pain will decrease to the level where the condition has recovered. The individual time for recovery will be different from patient to patient.

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other modalities within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Leslie Deems, L. Ac. or other licensed acupuncturists who now or in the future treat me while serving as her substitute.

I understand that methods of treatment may include acupuncture with sterile and disposable needles, TuiNa massage, cupping, Chinese herbal medicine and nutritional counseling. I understand that acupuncture is a safe method of treatment, but side effects may include bruising or tingling near the needling sites, dizziness or fainting.
Extremely rare risks include nerve damage, organ puncture and spontaneous miscarriage.

The herbs prescribed are considered safe in the practice of Oriental medicine. I understand that the herbs prescribed and given by the acupuncturist must be taken according to the practitioner's instruction only. I agree to inform the acupuncturist about any other herbs, medications or supplements that I am taking currently or during future courses of treatments. The herbs prescribed may have a strong medicinal taste. Occasional side effects may include digestive upset or allergic reactions. If any discomfort is noticed while taking the prescribed herbs, I understand to discontinue use and notify the office immediately. I understand that some herbs may be inappropriate during pregnancy. I agree to inform the acupuncturist 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. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist considers at the time, based upon the facts then known, and is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above "treatment information" and "informed consent." I have also had an opportunity to ask questions about the content, and by signing below I agree to the abovenamed procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE _____ Date _____/_____/_____ (or patient representative)

Financial Policy

Thank you for choosing our acupuncture office as your health care provider. The following is a statement of our Financial Policy, which we require that you read, and sign prior to treatment. We are happy to provide you with a copy for your records.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN WRITING PRIOR TO TREATMENT. Our office accepts cash & checks. All returned checks will incur a $25.00 (twenty-five) dollar fee, which will automatically be charged to your account.

Minor Patients

Minor children must be accompanied by a parent or guardian for all treatment. The parent or guardian is responsible for payment.

Missed Appointments

Your appointments are very important to us. They are reserved especially for you. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24 hour notice for cancellations or rescheduling of appointments.

Please understand that when you forget, cancel, or change your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and patients miss the opportunity to receive services.

Any appointment missed, late cancelled, or changed without 24 hour notice will result in a charge equal to 100% of the reserved service amount. The appointment may be taken off of a contract/package or charged individually.

Thank you for your understanding. We look forward to serving you.

Please let us know if you have any questions or concerns.

I have read the above Financial Policy. I understand and agree to the terms stated above.

_____ _____/_____/_____

Signature of Patient or Responsible Party Date