DUBLIN FAMILY CHIROPRACTIC
6365 Shier Rings Road, Suite A Dublin, OH 43016614.764.4001 fax 614.764.4002
www.DublinFamilyChiropractic.com

Acupuncture Form

Name _____ Date of Birth_____ Gender: M___ F ___
Address _____ City_____
State_____ Zip_____ Cell Phone_____

Employer _____ Work Phone_____ X_____
Work Address_____
Occupation_____

Social Security # _____ Marital Status: Sin___ Mar___ Div___ Sep___ Wid___

Emergency Contact:_____
Phone number:_____ Relation:_____

Email Address _____
Number of Children_____ Ages_____

Main Concerns

Please tell me about your major health and wellbeing concerns in order of how important they are to you. It will help if you include when and where you first noticed them and to what extent they affect your daily life now.

_____
_____
_____

Have you received a diagnosis for your concerns? If yes, what was the diagnosis?

_____
_____
_____

What kind(s) of treatment(s) have you tried or are currently using related to these concerns?

_____
_____

What results have you seen from the above treatment(s)?

_____
_____
_____

Please mark the severity of your chief concern on the following scale.

Not a problem ----------Worst imaginable

0 1 2 3 4 5 6 7 8 9 10

Please mark the greatest degree of severity of your chief concern that you have EVER experienced.

Not a problem ----------Worst imaginable

0 1 2 3 4 5 6 7 8 9 10

Personal Medical History

Please mark all that apply and explain as necessary.

☐ Allergies_____ ☐ Heart disease_____

☐Seizures_____

☐ Asthma_____ ☐ Hepatitis_____

☐Stroke_____

☐ Cancer_____ ☐High blood pressure_____

☐Thyroid disease_____

☐ Diabetes_____ ☐HIV/AIDS_____

☐Other_____

Please date and describe all hospitalizations and surgeries:

_____

_____

_____

Please date and describe all significant traumas:

_____

_____

_____

What do you know about your birth (prolonged labor, forceps, premature, etc)?

_____

_____

List all known allergies (food, chemicals, drugs, seasonal, insects, etc):

_____

_____

Have you undergone a course of antibiotics lately?

_____

Have you been under the care of a licensed health care professional in the past year?

_____

If so, for what reasons?

_____

Family Medical History

Please mark all that apply and explain as necessary, indicating which family member.

☐ Allergies_____ ☐ Drug/Alcohol abuse_____ ☐Seizures_____
☐ Asthma_____ ☐ Heart disease_____ ☐Stroke_____
☐ Cancer_____ ☐High blood pressure_____ ☐Thyroid disease_____
☐ Diabetes_____ ☐Mental disorder_____ ☐ Other_____

Review Of Symptoms

Past	Current	
		General
☐	☐	Catch cold easily
☐	☐	Recurrent infections
☐	☐	Night sweats
☐	☐	Bleed or bruise easily
☐	☐	Organ prolapsed
☐	☐	Strong thirst (hot or cold)
☐	☐	Fatigue /low energy
☐	☐	Sudden drops of energy
		Time of day _____
☐	☐	Sudden change in weight
		Sleep
☐	☐	Difficulty in falling asleep
☐	☐	Wake up easily at night
		Times per night?_____
		Particular time?_____
☐	☐	Wake up too early in am
		What time?_____
☐	☐	Nightmares
☐	☐	Vivid dreams
☐	☐	Grinding teeth
☐	☐	Talking in Sleep
		Circulation
☐	☐	Cold hands or feet
☐	☐	Swelling in hands/feet
☐	☐	Blood clots
☐	☐	Varicose veins
☐	☐	Edema/swollen ankles
☐	☐	Puffy eyes

Past	Current	
		Nervous System
☐	☐	Loss of taste/smell/touch
☐	☐	Tingling sensations/numbness
☐	☐	Tremors
		Where?_____
☐	☐	Lack of coordination/balance
☐	☐	Paralysis or seizures
☐	☐	Stroke
☐	☐	Concussion
☐	☐	Other_____
		Skin and Hair
☐	☐	Dry skin/scalp/hair
☐	☐	Rashes/hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Warts
☐	☐	Acne
☐	☐	Change in moles
☐	☐	Hair loss/thinning hair
☐	☐	Graying of hair
☐	☐	Other_____
		Mind and Emotions
☐	☐	Poor memory
☐	☐	Difficulty concentrating
☐	☐	Depression
☐	☐	Often stressed
☐	☐	Lose control of emotions
☐	☐	Substance abuse
☐	☐	Anxiety/nervousness
☐	☐	Manic behavior
☐	☐	Panic attacks
☐	☐	Easily angered
☐	☐	Aggressive behavior
☐	☐	Other_____

Past	Current	
		Chest
☐	☐	Pain in chest
☐	☐	Tightness or pressure in chest
☐	☐	Pain with breathing
☐	☐	Difficulty breathing
☐	☐	Shallow breathing
☐	☐	Shortness of breath
☐	☐	Recurrent/chronic cough
☐	☐	Coughing up blood
☐	☐	Coughing up phlegm
☐	☐	Asthma/wheezing
☐	☐	Production of phlegm
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Heart palpitations or rapid heartbeat
☐	☐	Irregular heartbeat
☐	☐	Other_____
		Muscles and Joints
☐	☐	Neck pain
☐	☐	Shoulder pain
☐	☐	Back pain
		Where?_____
☐	☐	Hand/wrist pain
☐	☐	Knee pain
☐	☐	Foot/ankle pain
☐	☐	Muscle pain/weakness
☐	☐	Tremors/tics in muscles
☐	☐	Osteoporosis
☐	☐	Herniated disc
☐	☐	Sciatica
☐	☐	Other_____

Past Current

Head, Ears, Eyes, Nose, Throat

- ☐ ☐ Headaches

Where?_____

When?_____

- ☐ ☐ Migraines
- ☐ ☐ Dizziness/Vertigo
- ☐ ☐ Fainting spells
- ☐ ☐ Earache
- ☐ ☐ Change in hearing
- ☐ ☐ Ringing in the ears
- ☐ ☐ Blurry vision
- ☐ ☐ Night blindness
- ☐ ☐ Color blindness
- ☐ ☐ Spots before eyes
- ☐ ☐ Dry eyes
- ☐ ☐ Eye pain/sore eyes
- ☐ ☐ Excessive tearing
- ☐ ☐ Glasses/contacts
- ☐ ☐ Facial pain
- ☐ ☐ Facial paralysis
- ☐ ☐ Nosebleeds
- ☐ ☐ Blocked nose/sinuses
- ☐ ☐ Sinus infections
- ☐ ☐ Jaw pain
- ☐ ☐ Teeth/gum problems
- ☐ ☐ Recurrent sore throat
- ☐ ☐ Hoarseness/loss of voice
- ☐ ☐ Tonsillitis/swollen glands
- ☐ ☐ Sores on lips/mouth/gums
- ☐ ☐ Strange taste in mouth
- ☐ ☐ Oral ulcers
- ☐ ☐ Other_____

Urinary

- ☐ ☐ Pain with urination
- ☐ ☐ Urgent urination
- ☐ ☐ Frequent urination
- ☐ ☐ Blood in urine
- ☐ ☐ Cloudy urine
- ☐ ☐ Dribbling urination
- ☐ ☐ Urinary incontinence/retention
- ☐ ☐ Incontinence at night
- ☐ ☐ Do you wake to urinate?
  How many times?_____
- ☐ ☐ Bladder/kidney infections
- ☐ ☐ Recurrent yeast infections
- ☐ ☐ Kidney stones

Past Current

Digestion

- ☐ ☐ Little appetite
- ☐ ☐ Strong appetite
- ☐ ☐ Hunger but no desire to eat
- ☐ ☐ Food cravings
- ☐ ☐ Belching
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Heartburn
- ☐ ☐ Indigestion
- ☐ ☐ Abdominal pain
- ☐ ☐ Regurgitation
- ☐ ☐ Weight loss
- ☐ ☐ Weight gain
- ☐ ☐ Loose stools/diarrhea
- ☐ ☐ Dysentery
- ☐ ☐ Strong smelling stools
- ☐ ☐ Blood in stools
- ☐ ☐ Constipation (<1 bm/day)
- ☐ ☐ and dry stools
- ☐ ☐ with difficulty
- ☐ ☐ Alternating constipation and diarrhea
- ☐ ☐ Gas/Flatulence
- ☐ ☐ Hernia
- ☐ ☐ Rectal pain/prolapsed
- ☐ ☐ Hemorrhoids
- ☐ ☐ Anorexia nervosa
- ☐ ☐ Bulimia
- ☐ ☐ Bad breath
- ☐ ☐ Other_____

Male System

- ☐ ☐ Prostate Problem
- ☐ ☐ Change in Sexual Drive
- ☐ ☐ Rashes/itching
- ☐ ☐ Genital Discharge
- ☐ ☐ Erection Difficulty
- ☐ ☐ Low Sperm count/ mobility

Past Current

Female System

- ☐ ☐ Premenstrual irritability
- ☐ ☐ Clots in menstrual blood
  Color of blood_____
- ☐ ☐ Irregular menses
- ☐ ☐ Painful menses
- ☐ ☐ Heavy/prolonged bleeding
- ☐ ☐ Missed menses
- ☐ ☐ Spotting/abnormal bleeding
- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal dryness
- ☐ ☐ Genital sores
- ☐ ☐ Ovarian cysts
- ☐ ☐ Fibroids
- ☐ ☐ Endometriosis
- ☐ ☐ Breast lumps
- ☐ ☐ Breast swelling or redness
- ☐ ☐ Nipple discharge
- ☐ ☐ Abnormal PAP smear
- ☐ ☐ Infertility
- ☐ ☐ Other_____

Are you currently pregnant?_____

Is it possible that you are currently pregnant?_____

Are you trying to get pregnant?_____

Do you practice birth control?_____

What type and for how long?_____

Number of pregnancies_____

Number of births_____

Number of premature births _____

Number of Abortions_____

Age of first menses_____

Duration of menses_____

Number of days in cycle_____

Age of menopause_____

Date of last pap_____

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Disclosure Statement

EDUCATION AND EXPERIENCE

Chris Cooper graduated from American Institute of Alternative Medicine (AIAM) in January 2014. AIAM is a three year program with a curriculum strongly emphasizing Traditional Chinese Medicine as well as Acupuncture. In June 2014, he gained his certification of Diplomate in Acupuncture (Dipl. Lac) as issued by the National Council of Colleges for Acupuncture and Oriental Medicine (NCCAOM). Ohio State Acupuncture License was awarded August 2014. Included in this certification is a course in Clean Needle Technique and First Aid/CPR. Chris's education also included adjunct therapies such as moxibustion, cupping, gua'sha, tuina, auriculotherapy, electro-acupuncture, and lifestyle and Traditional Chinese Medical (TCM) nutritional counseling. Chris holds a Masters Degree in Clinical Counseling from University of Dayton.

This clinic uses only single-use, disposable, factory-sterilized needles and complies with the rules and regulations promulgated by the Ohio Department of Public Health and Environment concerning proper cleaning and sanitation measures.

FEE SCHEDULE:

Initial Acupuncture Consultation and Treatment	$90.00
Fertility Acupuncture/Wellness Consultation and Treatment	$110.00
Follow-up Acupuncture Treatment	$70.00
Cupping Treatment	$70.00
(If added to acupuncture treatment)	($15.00)

I understand that if I need to reschedule an appointment for any reason, I will give at least 24 hours notice or be responsible for half of the session fee. If I don't call, or show up, I will be responsible for the full session fee.

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 termination therapy at any time. The practice of acupuncture is regulated by the Ohio State Medical Board.

I have read and understand this document.

_____ _____

Patient's Signature (or Signature of Guardian) Date

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STATEMENT OF INFORMED CONSENT

I hearby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by Chris Cooper, L. Ac., representing Dublin Family Chiropractic, 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:
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 should feel fine within a few minutes.

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's Signature (or Signature of Guardian) Date

_____ _____

Printed Name Phone Number

_____

Address City, State Zip