



Men's Acupuncture Intake Form

Name: _____ Date: _____

Address: _____ Zip: _____

Home: _____ Cell: _____

email: _____

Whom may we thank for referring you to our office? _____

Sex: M F Birthdate: ____/____/____

Single Married/Partnership Divorced Widowed Separated

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

RESPONSIBILITY AGREEMENT WITH CONSENT TO TREATMENT AND STATEMENT OF FINANCIAL POLICY

By signing below you acknowledge, understand and agree to the following:

1. I am responsible for payment for all services rendered - payment due in full at the time of service. Back To Health Center will provide a receipt for me to submit to my insurance company.
2. I understand that unless 24 hours advanced notice is given, I am financially responsible for cancelled or missed appointments.
3. I hereby consent to acupuncture and related holistic treatments and evaluations rendered to me (or my child if a minor) by Dr. Andrew R. Dyer DC. I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time.
4. Acupuncture is a healing therapy involving the insertion of fine needles into specific points along meridians on the body. In addition to the use of needles, the scope of acupuncture includes the use of electrical, mechanical or magnetic devices to stimulate acupuncture points, moxibustion, acupressure, cupping and/or infra-red therapy.
5. Acupuncture side effects may include some pain following treatment in the insertion area, temporary aggravation of symptoms existing prior to treatment, minor bruising, slight bleeding, dizziness, infection or needle sickness (fainting).
6. **If you are pregnant, taking anti-coagulant drugs (Coumadin), have a bleeding disorder, diabetes, heart condition, circulatory problems, blood clots, blood borne disease such as HIV or Hepatitis, cancer/malignancies, bone disorders, metal implants or have a pacemaker you should make that information known to Dr. Andrew Dyer DC prior to treatment.**
7. Acupuncture treatment is a complement to and not a substitute for Western medical care. Certain conditions may best be addressed in partnership with other health care providers.
8. I understand that my acupuncture practitioner follows universally prescribed precautions to guard against the spread of infection by using only sterilized, prepackaged, disposable needles. These needles will only be used on me and are inserted according to clean procedures based on nationally prescribed standards.

I have read and understand/agree to the information on this consent form.

Name: _____ Date: _____

Signature: _____



Acupuncture Patient Questionnaire

Have you had acupuncture before? Y N

Do you currently see a medical doctor? Y N

Name of Doctor: _____ Phone: _____

Address: _____

City: _____ St: _____ Zip: _____

Doctor's Diagnosis: _____

How are you responding to your present course of treatment? Better Worse Same

Date of last appt with regular Physician: _____

Family Medical History:

- Cancer Diabetes Heart Disease Stroke Depression
- Seizure Hepatitis Thyroid Disease Alcoholism High Blood Pressure
- Other _____

Please indicate if any of the following apply to you:

- Cancer Heart Condition HIV/AIDS Stroke/CVA
- Diabetes Hemophiliac Lung Condition Takes Anticoagulants
- Epilepsy Hepatitis Pacemaker Vegetarian/Vegan

Surgeries: _____

Significant Trauma: _____

Birth History: _____

Allergies: _____

Exercise (type, duration, frequency): _____

Are you pregnant or is there any chance that you are pregnant? Y N

Medications: (list any medications, vitamins or food supplements taken in past two months)

Name:

Dosage:

WEIGHT: _____ **HEIGHT:** _____

Have you experienced any height or weight gains/losses over the past year? Y N

Explain: _____

LIFESTYLE:

What are your primary sources of stress?

- 1.
- 2.
- 3.

How much do you think they impact you life? _____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments:
Spouse/Significant Other						
Family						
Diet						
Self						
Work						
Exercise						
Spirituality						

Occupation? _____ Do you like your work? Y N

How many hours do you work per week? _____ Number of play/relaxation hours? _____

What do you do in order to manage stress and take care of yourself? : _____

What do you believe is your greatest challenge? _____

What do you think you need to do in order for you vision of health to happen? _____

What type of care do you desire?

- Temporary relief of symptoms/pain control
- Elimination of root cause of problem, if possible
- Maintenance care/balance to stay in good health
- Other _____

How would you classify your condition:

- Minor
- Worsening
- Serious
- Severe/Life Altering

What other therapies have you tried for this condition: _____

CURRENT MEDICAL STATUS:

Date of last full physical? _____ If abnormal, explain: _____

Any personal history of skin cancer? Y N

If over age 50, have you had a colonoscopy? Y N Date of colonoscopy? _____

Any positive findings on colonoscopy? Y N If yes, explain: _____

Date of last eye exam? _____ If abnormal, explain: _____

Do you visit the dentist regularly? Y N How frequent? _____

Do you have dental problems, gum inflammation or gingivitis? Y N

Explain: _____

DIET:

Are you on a restrictive diet? Y N

Is your diet physician prescribed? Y N If yes, for what condition? _____

Do you consider your diet healthy? Y N

Please describe a typical day's diet...

Breakfast	Lunch	Dinner	Snacks (what hou

Estimated oz of water per day: _____

Caffeine Intake: None Coffee Tea Cola/Energy Drinks
 # of cups/cans per day _____

Do you consume alcohol? Y N
 If yes, what type? _____ How many drinks per week? _____

Do you use tobacco? Y N If yes, what kind? _____
 How many per day? _____ Number of years used: _____

Do you use recreational drugs? Y N
 Type of drug: _____ Frequency: _____

INDICATE WITH NUMBERS AS FOLLOWS: (Leave blank any symptoms which do not apply)

1 – any condition occasionally experienced

2 – conditions which occur often

3 – symptoms which are a major concern

Water Element

- ___ Asthmatic Cough
- ___ Cold Intolerance
- ___ Dark Under Eyes
- ___ Diabetes
- ___ Dizziness
- ___ Edema
- ___ Emotional Instability
- ___ Excess Fear
- ___ Frequent Urination
- ___ Hair Thinning/Loss
- ___ Hearing Loss
- ___ Kidney Stones
- ___ Loose Teeth/Loss
- ___ Low Back Pain
- ___ Neck Pain
- ___ Perspire Easily
- ___ Premature Aging
- ___ Rapid Weight Change
- ___ Reduced Sexual Energy
- ___ Sinus Congestion
- ___ Thyroid Problems
- ___ Weak Legs/Knees

Wood Element

- ___ Constipation
- ___ Convulsions
- ___ Dry Eyes
- ___ Eczema
- ___ Eye Infection
- ___ Fullness Below Ribs
- ___ Gallstones
- ___ Headaches
- ___ Hemorrhoids
- ___ Hepatitis
- ___ Herpes
- ___ Indecisive
- ___ Insomnia
- ___ Irritability
- ___ Migraines
- ___ Neck Tension
- ___ Nervousness
- ___ Poor Eyesight
- ___ Ringing In Ears
- ___ Shingles
- ___ Shoulder Tension
- ___ Spasms
- ___ Ulcer
- ___ Vomiting
- ___ Warts

Fire Element

- ___ Bitter Taste In Mouth
- ___ Cysts/Tumors
- ___ Dark Urine
- ___ Dry Scalp
- ___ Ear Infection
- ___ Excess Joy
- ___ Facial Redness
- ___ Gum Problems
- ___ Heart Palpitations
- ___ Heat Intolerance
- ___ Hot Palms/Soles
- ___ Itch/Burning Skin
- ___ Lymph Swelling
- ___ Night Sweats
- ___ Nose Bleeds
- ___ Skin Rash
- ___ Sore Throat
- ___ Thirst
- ___ Vivid Dreaming

Other

- ___ Arthritis
- ___ Bursitis/Tendonitis
- ___ Cold Hands/Feet
- ___ Fatigue
- ___ Nerve Pain
- ___ Sciatica

Metal Element

- ___ Allergies
- ___ Asthma
- ___ Bronchitis
- ___ Cough
- ___ Grief/Weeping
- ___ Nose Infection
- ___ Sinus Problems
- ___ Skin Problems
- ___ Weak Breath

Earth Element

- ___ Acid Reflux
- ___ Anemia
- ___ Big Appetite
- ___ Bloating
- ___ Diarrhea
- ___ Excess Worry
- ___ Flatulence
- ___ Food Allergy
- ___ Halitosis
- ___ Heartburn
- ___ Indigestion
- ___ Mouth Sores
- ___ Obsessive
- ___ Stomach Ache
- ___ Ulcer
- ___ Underweight
- ___ Weak Appetite

Other Symptoms/Systems:

Please indicate if you regularly experience any of the following:

Head & Neck:

- Dizziness
- Enlarged lymph glands
- Other: _____
- Fainting
- Headache
- Migraine
- Stiff neck

Eyes & Ears:

- Burning/itching eyes
- Blurred vision
- Chronic ear infection
- Decreased hearing
- Other: _____
- Dry eyes
- Earache
- Eye pain
- Poor night vision
- Ringing in ears
- Spots/floaters
- Vertigo
- Visual changes

Respiratory/Nose:

- Bronchitis
- Chronic Cough
- Chronic sinus infection
- Coughing up blood
- Other: _____
- Cough with phlegm
- Difficulty breathing
- Frequent Colds
- Hay fever/allergies
- Nasal congestion
- Nosebleeds
- Shortness of breath
- Wheezing/Asthma

Genital/Urinary:

- Bedwetting
- Blood in urine
- Decreased libido
- Excessive/scant urination
- Other: _____
- Frequent urination
- Genital lesions/discharge
- Kidney Stone
- Increased libido
- Nighttime urination
- Pain/itching of genitalia
- Painful/burning urination
- Urgent urination

Cardiovascular:

- Chest pain/tightness
- Heart palpitations
- Other: _____
- Irregular heart beat
- Poor circulation
- Swelling feet/ankles
- Varicose veins

Mouth & Throat:

- Bitter taste in mouth
- Bleeding gums
- Difficulty swallowing
- Dry mouth
- Lump in throat
- Recurrent sore throat
- Tongue/Mouth sores/ulcers

Muscles & Joints:

- Body aches/stiffness
- Generalized weakness
- Heaviness" of body/limbs
- Joint discoloration
- Joint pain
- Other: _____
- Joint swelling
- Numbness/tingling

Skin:

- Acne
- Brittle/weak nails
- Bruise easily
- Changes in moles/lumps
- Dry skin
- Eczema/psoriasis
- Hives/Rashes
- Other: _____
- Itchy skin
- Night sweats
- Spontaneous sweat

Gastrointestinal:

- Acid reflux/heartburn
- Anal fissures
- Bad breath
- Black stool
- Bloating
- Other: _____
- Blood in stool
- Constipation
- Gas
- Hemorrhoids
- Hiccups
- Intestinal pain/cramping
- Loose/soft stool
- Mucous in stool
- Nausea
- Vomiting

Appetite/Thirst:

Temp of drinks most commonly desired: Very cold Tepid Very Hot

- Exceedingly hungry No thirst
- Excessive thirst Poor appetite
- Hunger w/no desire to eat Thirst w/no desire to drink
- Other: _____

Sleep:

- Difficulty waking up Trouble staying asleep
- Sound/restful Vivid dreaming/nightmares
- Trouble falling asleep Wake easily
- # hours sleep/night: _____ Other: _____

Emotions:

- Angry/Frustrated Fearful Manic
- Anxious Forgetful/poor memory Relaxed/calm
- Depressed/sad Impatient Stressed
- Other: _____

General:

- Always feel cold Cold hands/feet Fever& Chills
- Always feel hot Fatigue Recent unexplained weight changes
- Other: _____

MEN ONLY: (please check all that apply)

- Groin Pain Painful Urination Reduced Sexual Energy
- Impotence Premature Ejaculation Seminal Emission
- Infertility Prostate Problems Trouble With Urination
- Date of last prostate exam: _____

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