**Men's Acupuncture and**
**Emotional Bodywork Intake**

Date:_____

Name:_____ E-mail:_____

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

Best Phone #:_____ This is my: ☒ Home ☒ Cell ☒ Work Birthday:___/___/___

Emergency Contact:_____ Phone #:_____

Who can we thank for referring you? ☒ Facebook ☒ Twitter ☒ Yelp ☒ LW Website

☒ Internet Search ☒ Signs ☒ Gift Card ☒ Coupon/Promotion ☒ Person: (Who?)_____

**Please write in your top 3 health complaints/concerns in order of importance to you:**

1.)_____

2.)_____

3.)_____

**Medications -** Please note any medications, herbs or supplements you take regularly:

_____

**Injuries & Surgeries -** Please list any medical/dental/cosmetic surgeries and the year occurred:

_____

**Habits -** Please note weekly intake of the following (if quit, indicate the year):

Coffee/Tea:_____ Alcohol:_____

Tobacco:_____ Drugs:_____

Soda:_____ Other:_____

**Health History -** Please check any and all that apply:

| Yes | No | Family | |
|---|---|---|---|
| ☒ | ☒ | ☒ | Cancer, type(s):_____ |
| ☒ | ☒ | ☒ | Diabetes |
| ☒ | ☒ | ☒ | Anemia |
| ☒ | ☒ | ☒ | High blood pressure |
| ☒ | ☒ | ☒ | Heart disease or circulartory problems:_____ |
| ☒ | ☒ | ☒ | Stroke |
| ☒ | ☒ | ☒ | Implantation/pacemaker:_____ |
| ☒ | ☒ | ☒ | Kidney disease |
| ☒ | ☒ | ☒ | Thyroid disease |
| ☒ | ☒ | ☒ | Epilepsi or seizure disorder |
| ☒ | ☒ | ☒ | Asthma |
| ☒ | ☒ | ☒ | Allergies, type(s):_____ |
| ☒ | ☒ | ☒ | Osteoperosis |
| ☒ | ☒ | ☒ | Mental illness:_____ |
| ☒ | ☒ | ☒ | AIDS/HIV |
| ☒ | ☒ | ☒ | Other STD, herpes:_____ |
| ☒ | ☒ | ☒ | Frequent headaches |
| ☒ | ☒ | ☒ | I have experienced professional massage or bodywork before |
| ☒ | ☒ | ☒ | I bruise easily |
| ☒ | ☒ | ☒ | Joint swelling |
| ☒ | ☒ | ☒ | Are you in any stage of or have symptoms of menopause? |
| ☒ | ☒ | ☒ | Do you wear contact lenses? |
| ☒ | ☒ | ☒ | Are you experiencing hair loss? |
| ☒ | ☒ | ☒ | Do you smoke? |
| ☒ | ☒ | ☒ | Do you exercise? |
| ☒ | ☒ | ☒ | Are you dieting or fasting now? |
| ☒ | ☒ | ☒ | Are you on birth control? |
| ☒ | ☒ | ☒ | Eczema or other skin condition?:_____ |
| ☒ | ☒ | ☒ | Colitis |
| ☒ | ☒ | ☒ | Candida |
| ☒ | ☒ | ☒ | Varicose veins |
| ☒ | ☒ | ☒ | Arthritis |

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**Health History for Men:** Please check any and all that apply

**Tempature:**
☒ Cold hands or feet
☒ Chills
☒ Cold "in the bones"
☒ Areas of numbness
☒ Thirst for cold/hot drinks
☒ Thirst, no desire to drink
☒ Absence of thirst
☒ Excessive thirst
☒ Night sweats
☒ Unusual sweats
☒ If so, when?_____am/pm. Area of body:_____
☒ Hot hands/feet/chest
☒ Hot flashes
☒ Hot in the afternoon
☒ Hot at night

**Moisture:**
☒ Dry skin
☒ Dry hair
☒ Dry eyes
☒ Dry/brittle nails
☒ Dry mouth
☒ Dry lips
☒ Dry throat
☒ Dry nose/nosebleeds
☒ Edema/swelling
☒ Rashes
☒ Itching
☒ Dandruff
☒ Oily skin
☒ Oily hair
☒ Acne
☒ Weight loss/gain

**Digestion:**
BM:___x every ___ day(s)
Stool keeps shape?: Y / N
☒ IBS
☒ Indigestion
☒ Gas
☒ Bloating
☒ Belching
☒ Poor appetite
☒ Nausea/vomiting
☒ Bad breath
☒ Heartburn
☒ Excessive hunger
☒ Dry stools
☒ Difficult to pass
☒ Tired after BM
☒ Foul smelling stools

**Reproductive:**
Are you sexually active? Yes__ No__
☒ Change of sex drive
☒ Erectile dysfunction
☒ Premature ejaculation
☒ Sores on genitals
☒ Discharge
☒ Prostate disease
☒ Genital pain
☒ Jock itch
☒ Vasectomy
☒ Hernia
☒ Hemorrhoids

**Energy:**
☒ Sudden energy drop, time of day _____am/pm
☒ Energy drop after eating
☒ Fatigue
☒ Dependence on caffeine
☒ "Wired" feeling
☒ Body/limbs feel heavy or weak
☒ Shortness of breath
☒ Heart palpitations
☒ Blood pressure high/low
☒ Bleed/bruise easily
☒ Hard to concentrate
☒ Poor memory
☒ Dizziness/lightheaded
☒ Headaches ____x/week

**Emotions:** What emotion(s) dominate?
☒ Anger
☒ Irritability
☒ Anxiety
☒ Worry
☒ Sadness
☒ Depression
☒ Obsessive thought
☒ Joy
☒ Fear
☒ Timid/shy
☒ Indecision

**Eyes, Ears, Nose, Throat:**
☒ Poor vision
☒ Night blindness
☒ Red eyes
☒ Itchy eyes
☒ Seeing spots
☒ Sinus congestion
☒ Phlegm
☒ Poor hearing
☒ Ringing in the ears
☒ Excessive earwax
☒ Sore throat
☒ Dental problems
☒ Mouth sores
☒ Cough

**Urinary:**
Fluid in = fluid out? Yes__ No__
☒ Decrease in flow
☒ Dribbling
☒ Difficult start/stop
☒ Incontinence
☒ Kidney stones
☒ Urgency to urinate
☒ Frequent urination
☒ Pain on urination
☒ Burning sensation
☒ Coludy urine
☒ Blood in urine
☒ Kidney stones

**Sleep:**
Number of hours per night:_____
☒ Difficulty falling asleep
☒ Wake ___x/night ____am/pm
☒ Wake to urinate ___x
☒ Disturbing dreams
☒ Restless sleep
☒ Not rested upon waking

**LivingWell**
**Consent to Treatment Form**

By signing below, I do hereby voluntarily consent to be treated with acupuncture and its adjunct therapies; acupressure, electromagnetic stimulation, cupping, moxibustion, exercise, bodywork, nutritional counseling, elimination technique, NAET and substances from the Oriental Materia Medica by a licensed acupuncturist at LivingWell. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important part of my health care plan.

Acupuncture/Moxibustion: I understand that acupuncture and it's adjunct therapies performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body to treat bodily dysfunction or diseases, relieve pain, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, in combination with or in lieu of acupuncture.

Because some therapies should not be done under certain conditions, all known medical conditions should be disclosed to the acupuncturist.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: X_____ Date: _____

Signature of Parent/Guardian (if under 18 yrs. of age): X_____ Date: _____

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**LivingWell Policies**

In consideration of all involved, broken appointments without 24 hours notice will be charged 50% of the appointment cost. Missed appointments cannot be billed to my insurance company.

My signature below indicates that I have read, understand and agree to the information enclosed and I release LivingWell, its employees, associates and assigns from all liability.

Signature: X_____ Date: _____

Signature of Parent/Guardian (if under 18 yrs. of age): X_____ Date: _____