Treatment Recommendation:
_____x/week _____weeks

Living*Well*

207 Washington Street
Salem, MA 01970
www.LivingWellSalem.com

Name: _____ E-mail: _____

Address: _____ City: _____State:_____ Zip:_____

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

Emergency Contact: _____ Phone #:_____

Preferred Method of Communication: ☐Phone ☐E-Mail ☐Text phone provider:_____

Who can we thank for referring you? ☐Facebook ☐Twitter ☐Yelp ☐LW Website ☐Internet Search ☐Signs ☐Coupon/Promotion ☐Person: (Who?) _____

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Circle the 🧍 if you have / had the condition and note the year it started.
Circle the 👪 if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer *type(s)?*	🧍	_____	👪
Diabetes	🧍	_____	👪
Hepatitis	🧍	_____	👪
High Blood Pressure	🧍	_____	👪
Heart Disease	🧍	_____	👪
Stroke	🧍	_____	👪
Seizure Disorder	🧍	_____	👪
Thyroid Disease	🧍	_____	👪
Asthma	🧍	_____	👪
Pacemaker	🧍	_____	👪
Osteoporosis	🧍	_____	👪
Herpes	🧍	_____	👪
AIDS / HIV	🧍	_____	👪
Other STD	🧍	_____	👪
Rheumatic Fever	🧍	_____	👪
Alcoholism	🧍	_____	👪
Allergies *type(s)?*	🧍	_____	👪
Mental Illness	🧍	_____	👪
Kidney Disease	🧍	_____	👪
Anemia	🧍	_____	👪

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No
If so, what and how often:

_____
_____
_____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATONS

Please note what medications, herbs or supplements that you take regularly

_____
_____
_____

INJURIES & SURGURIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

HEALTH HISTORY FOR WOMEN

Please mark an X on the scales, and check any boxes of symptoms you have had in the past month.

TEMPERATURE

How warm/cold you feel (not in degrees)

COLD_____/_____HOT

o Cold hands or feet	o Thirst for cold/hot drinks	o Night sweats	o Hot hands/feet/chest
o Chills	o Thirst, no desire to drink	o Unusual sweats	o Hot flashes
o Cold "in the bones"	o Absence of thirst	When_____am/pm	o Hot in afternoon
o Areas of numbness	o Excessive thirst	Where on body:	o Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY_____/_____OILY

o Dry skin	o Dry mouth	o Edema/Swelling:	o Oily skin
o Dry hair	o Dry lips	o Rashes:	o Oily hair
o Dry eyes	o Dry throat	o Itching:	o Acne
o Dry/brittle nails	o Dry nose/nosebleeds	o Dandruff	o Weight gain/loss

DIGESTION

DIARRHEA_____/_____CONSTIPATION

BM: ___x every ___ day	o Gas	o Nausea/Vomiting	o Dry stools
Stool keeps shape _Y_N	o Bloating	o Bad breath	o Difficult to pass
o IBS	o Belching	o Heartburn	o Tired after BM
o Indigestion	o Poor appetite	o Excessive hunger	o Foul smelling stools

ENERGY

LOW_____/_____HIGH

o Sudden energy drop:	o Dependence on caffeine	o Shortness of breath	o Hard to concentrate
Time of day ____ am/p,	o "Wired" feeling	o Heart palpitations	o Poor memory
o Energy drop after eating	o Body/limbs feels heavy	o Blood pressure high/low	o Dizziness/lightheaded
o Fatigue	o Body/limbs feel weak	o Bleed/bruise easily	o Headaches ____x/week

SLEEP

hours per night _____

o Difficulty falling asleep
o Wake __x/night ___am/pm
o Wake to urinate _____x
o Disturbing dreams
o Restless sleep
o Not rested upon waking

EMOTIONS

What emotion(s) dominate?

o Anger	o Obsessive thought
o Irritability	o Joy
o Anxiety	o Fear
o Worry	o Timid/Shy
o Sadness	o Indecision
o Depression	

EYES, EARS, NOSE, THROAT

o Poor vision	o Poor hearing
o Night blindness	o Ringing in ears
o Red eyes	o Excess earwax
o Itchy eyes	o Sore throat
o Seeing spots	o Dental problems
o Sinus congestion	o Mouth sores
o Phlegm	o Cough

MENOPAUSE:	Age at last menses: ____	o Hot flashes	o Vaginal dryness
	Year changes began: ___	o Night sweats	o Loss of sex drive

MENSES

Age at first menses:_____	o Heavy periods	o Cramps:	o Mood changes
Length of cycle ____ days	o Light periods	Before bleeding ___	o Fatigue
Last menses date _____	o Painful periods	First day ____	o Digestive changes
# of pregnancies _____	o Irregular periods	During period ____	o Midcycle spotting
# of births ___	o PMS	o Clots	o Yeast infections
# of abortions/miscarriage		o Breast tenderness	o Birth control pill

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or 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 is 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.

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: _____