Still Waters Healing Center

407-772-9243 stillwatershealing.com

Name_____ Date_____

Address_____ _____

City_____ State_____ Zip_____

Married Single Partner Divorced Widowed Date of Birth_____

SS#_____ Email_____

Work Phone_____ Home Phone_____

Cell Phone_____ Occupation_____

Referred by_____ Emergency Contact_____

Family Physician_____ Contact_____

May we contact them? Y / N Have you ever had Acupuncture or Oriental Medicine before? Y / N

Are you presently under a doctor's care? Y / N

Who and for what?_____

Are there any other therapies which you are involved? Y / N

Who and for what?_____

What is your primary reason for seeking care at our office?_____

What was the initial cause?_____

When did it begin?_____

What makes it worse?_____

What makes it better?_____

How does this problem interfere with your daily activities?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other _____
- _____

What have you done about this?_____

Are you interested in:

- ☐ Pain Relief
- ☐ Preventative Care
- ☐ Oriental Nutrition
- ☐ Performance Care
- ☐ Holistic Health
- ☐ Maintenance Care
- ☐ Stress Relief
- ☐ Herbal Therapy
- ☐ Other _____
- _____

What are your health goals?

_____

_____

List any past or future surgeries:

_____
_____

List any significant trauma. When did they occur? (auto accident, falls, emotional, sexual, etc…)

_____
_____

List exercise and sport activities you have been or are currently involved in:

_____
_____

Overall Energy (Lung, Kidney function):

- □Shortness of Breath
- □Difficulty keeping eyes open In the daytime
- □Overall Weakness
- □Easily Catch Colds
- □Low Energy
- □Feel worse after exercise

Heart Function:

- □Palpitations
- □Anxiety
- □Sores on the tip of tongue
- □Lack of Taste
- □Mental Confusion
- □Chest pain traveling to shoulder
- □Frequent Dreams
- □Wake up tired
- □Insomnia
- □Mental Sluggishness
- □Mental Fogginess
- □Night Sweats

Spleen Function:

- □Low appetite
- □Growing Hunger
- □Abrupt Weight loss
- □Weight Gain
- □Abdominal Bloating
- □Abdominal gas
- □Gurgling noise in stomach
- □Fatigue after eating
- □Prolapsed organs (organ? :_____)

Lung Function:

- □Nasal Discharge (Color :_____)
- □Cough
- □Nose Bleeds
- □Sinus Congestion
- □Dry Mouth
- □Dry Throat
- □Dry Nose
- □Dry Skin
- □Allergies (To What? _____)
- □Alternating chills and fever
- □Sneezing
- □Headache (Location :_____)
- □Overall achy feeling in body
- □Stiff Neck
- □Stiff Shoulders
- □Sore Throat
- □Difficulty Breathing
- □Sadness
- □Melancholy
- □Smoke Cigarettes (# per day :_____)

- □Easily Bruised
- □Hemorrhoids
- □Over-Thinking
- □Worry

Blood (Liver, Spleen, Heart Functions):

- □Dizziness
- □See Floating Spots
- □Poor Memory
- □Pale Skin

Spleen, Stomach, Large Intestine, Small Intestine function:

- □Loose Stools
- □Constipated
- □Incomplete
- □Diarrhea
- □Blood in Stools
- □Mucous in Stools
- □Undigested Food in Stools

Dampness:

- □Heavy Sensation in body
- □Mental Heaviness
- □Swollen Hands
- □Swollen Feet
- □Swollen Joints
- □Chest Congestion
- □Nausea
- □Snoring

Stomach Function:

- □Burning Sensation after eating
- □Very large appetite
- □Bad Breath
- □Mouth (Canker Sores)
- □Bleeding, Swollen/Painful Gums
- □Heartburn
- □Acid Regurgitation
- □Ulcer (Diagnosed)
- □Belching
- □Hiccups
- □Stomach Pain
- □Vomiting

Liver, Gallbladder function:

- □Alternating Diarrhea/Constipation
- □Chest Pain
- □Tight Sensation in the Chest
- □Bitter taste in the mouth
- □Anger Easily
- □Frustration
- □Depression
- □Irritability
- □Frequent inability to adapt to stress
- □Skin Rashes
- □Headache at top of the head
- □Tingling Sensation
- □Numbness
- □Muscle Spasms
- □Muscle Twitching
- □Muscle Cramping
- □Seizures
- □Convulsions
- □Lump in the Throat
- □Neck Tension
- □Limited Range of Motion in Shoulders
- □Drink Alcohol
- □High pitched ringing in ears
- □Gall Stones

Kidney, Bladder functions:

- □Frequent Cavities
- □Easily Broken Bones
- □Sore Knees
- □Weak Knees
- □Cold Sensation in the knees
- □Low Back Pain
- □Memory Problems
- □Excessive Hair Loss
- □Low Pitch Ringing in Ears
- □Kidney Stones
- □Bladder Infections
- □Wake during the night to urinate, (How many times? _____)
- □Lack of bladder control
- □Fear
- □Easily Startled

Urination:

- □Normal Color
- □Dark Yellow
- □Clear
- □Reddish
- □Cloudy
- □Scanty
- □Profuse
- □Strong Odor
- □Burning
- □Painful
- □Difficult
- □Urgent
- □Frequent

Overall Temperature (Kidney function):

- □Cold Hands
- □Cold Feet
- □Sweaty Hands
- □Sweaty Feet
- □Heat in the hands, feet or chest
- □Hot Flashes
- □Night Sweats
- □Hot body temperature (sensation)
- □Cold body temperature (sensation)
- □Lack of Perspiration
- □Perspire Easily
- □Thirsty
- □Take Water to Bed
- □Difficulty keeping eyes open in the daytime

Eyes (Liver function):

- □Itchy
- □Bloodshot
- □Hot
- □Dry
- □Watery
- □Gritty
- □Blurry Vision
- □Decreased night vision
- □Near Sighted
- □Far Sighted

Libido:

□Normal □High □Low

Women Only:

Age of first menstruation: _____
Regular menstruation cycle? □Y □N
Average # days of flow? _____
Pregnant? □ Yes □ No
Number of children? _____
Number of pregnancies? _____
Age at menopause? _____
Vaginal Discharge:

- □Severe
- □Moderate
- □Slight
- □Normal

Bleeding between periods?

- □Severe
- □Moderate
- □Slight
- □Normal

Do you experience any of the following pre-menstrual syndromes?

- □Nausea
- □Anxiety
- □Headaches
- □Food Cravings
- □Depression
- □Migraines
- □Irritability
- □Vomiting
- □Water Retention
- □Breast Tenderness
- □Breast Swelling

Do you have any allergies? Y / N If so, to what?
_____
_____
_____

Do you take supplements? Y / N If so what types and how often?
_____
_____

Do you take medication? Y / N If so what types and how often?
_____
_____
_____
_____
_____

Do you sleep well? Y/N Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____ Do you have a low point during the day? Y/N When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

VII Web of Wellness

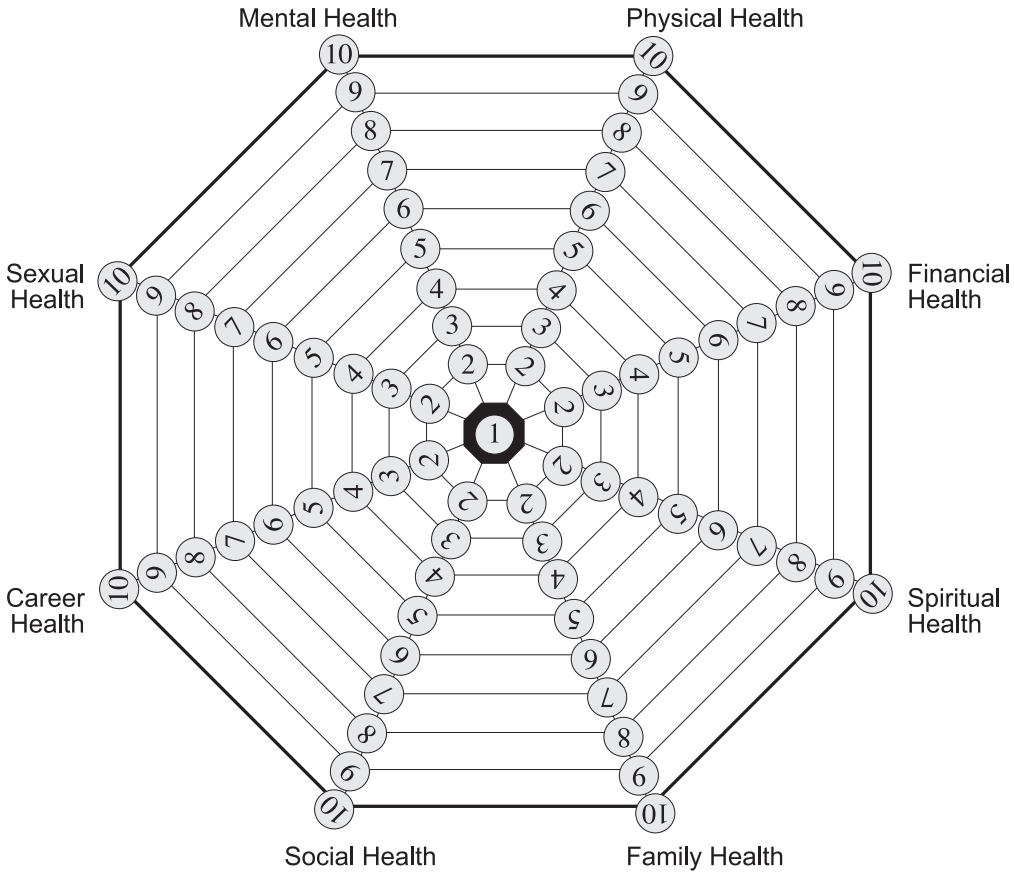
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



VIII Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain

Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep

Work - Can do:

Usual work	25% of work	50% of Work	No work

Frequency of pain

25% of time	50% of time	75% of time	100% of time

Travel

No problem on long trips	Moderate pain on trips	Severe pain

Recreation - Can do:

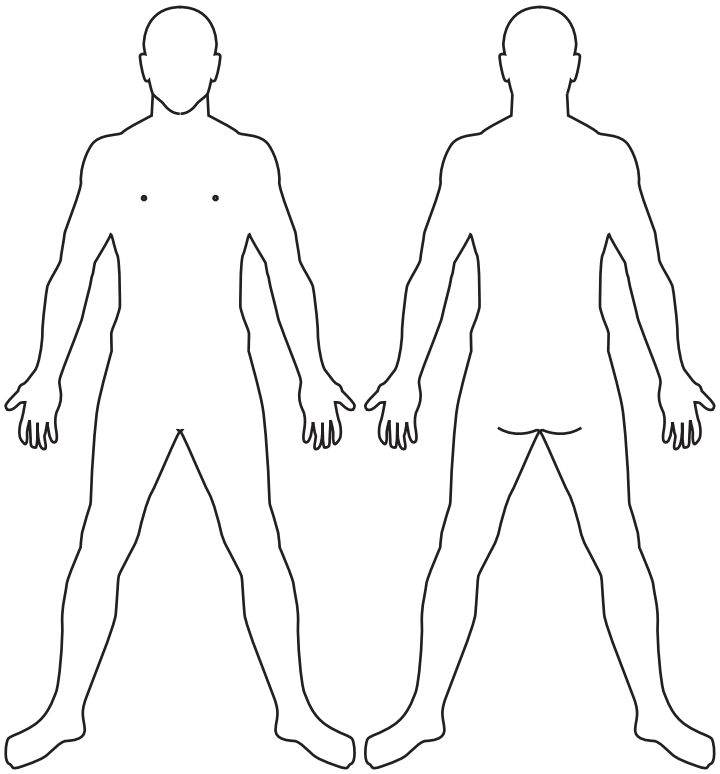
All activities	Some activities	No activities

Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit



Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.

Acute Care
Obvious symptoms and signs
Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care
Symptom and signs disappear
Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care
You feel great
Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

When a client seeks acupuncture health care and I accept a patient for such care, it is essential for both to be working toward the same objectives.

Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood, and other body fluids. When this is done correctly, the body will have the capacity to obtain and maintain health and well-being.

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Acupoint stimulation: The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

Health: A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

Qi imbalance: When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential

I do not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination I encounter non-acupuncture or unusual findings, I will advise you. If you desire advice, diagnosis or treatments of those findings, I will recommend that you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help to facilitate healing and a potentially lead to a full expression of your body's innate wisdom.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept acupuncture care on this basis.

(Signature) _____ (date) _____