



801 W Main St, Suite 1C  
Bozeman, MT 59715  
Ph. (406) 219-3631  
Fax (406) 760-1809  
[www.ElevateHealthMT.com](http://www.ElevateHealthMT.com)

### ACUPUNCTURE INTAKE - ADULT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Do you see any of our other providers at Elevate Health?  Yes  No

If yes, which provider(s)? \_\_\_\_\_

Are you currently receiving healthcare from any providers outside of Elevate Health?  Yes  No

If yes, please list providers' names and type of practitioner(s): \_\_\_\_\_

\_\_\_\_\_

If no, when and where did you last receive healthcare? \_\_\_\_\_

What was the reason? \_\_\_\_\_

Have any of your family members been seen at Elevate Health?  Yes  No

If yes, what are their names? \_\_\_\_\_

### HEALTH CONCERNS

What are your top health concerns/goals? Please list in order of importance:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

**What is your present level of commitment to correct your health concerns? (10 = 100% committed.)**

**0      1      2      3      4      5      6      7      8      9      10**

Do you have any known contagious illnesses at this time?  Yes  No If yes, what? \_\_\_\_\_

\_\_\_\_\_

### ALLERGIES

No Known Allergies

Are you hypersensitive or allergic to:

Any drugs?  Yes  No \_\_\_\_\_

Any foods?  Yes  No \_\_\_\_\_

Any environmental or chemical allergens?  Yes  No \_\_\_\_\_

**HEALTH HISTORY**

**ILLNESS/INJURY/SURGERY/HOSPITALIZATIONS:** Please list any serious illnesses, injuries, surgeries, or hospitalizations you have had and the year they occurred:

Illness/Injury/Surgery/Hospitalization	Year	Illness/Injury/Surgery/Hospitalization	Year

**TRAUMA:** Please list any significant traumatic events your have experienced and dates of occurrence (e.g. divorce, injury, family loss, bankruptcy, etc.):

Event	Date	Event	Date

**CHILDHOOD ILLNESSES:** Where you often ill as a child?  Yes  No

Please list any childhood illnesses:

Illness	Date	Illness	Date

**CURRENT MEDICATIONS & SUPPLEMENTS:** Please list any prescription **medications, over-the-counter medications, vitamins** or other **supplements** you are taking (attach an extra page if you need more room):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MUSCULOSKELETAL/PAIN MANAGEMENT** (Complete if you are seeking treatment for pain)

Where is your pain located? \_\_\_\_\_ Does it move, where? \_\_\_\_\_

Onset of pain: \_\_\_\_\_ Rate pain 1-10 (10=worst pain): \_\_\_\_\_ How often does it occur? \_\_\_\_\_

What event/events led to your pain? \_\_\_\_\_

What factors affect your pain? (Check B if it makes it Better or W if it makes it Worse):

- Heat:  B  W    Sitting:  B  W    Soft Pressure:  B  W
- Cold:  B  W    Standing:  B  W    Hard Pressure:  B  W
- Noise:  B  W    Walking:  B  W    Laying Down:  B  W
- Coughing:  B  W    Anxiety/Emotions:  B  W    Weather Changes:  B  W

Particular Positions (please describe): \_\_\_\_\_

Does your pain affect your life?  Yes  No If yes, please describe: \_\_\_\_\_

**FAMILY HISTORY** (Please list any family physical or mental health illnesses and age of death:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Grandparents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Children: \_\_\_\_\_

**LIFESTYLE HABITS**

Describe your typical diet:

Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_ Snacks: \_\_\_\_\_

Specific Restrictions/Diet Types: \_\_\_\_\_

<b>Do you:</b>	<b>Yes</b>	<b>No</b>	
Exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Describe exercise:
Watch TV?	<input type="checkbox"/>	<input type="checkbox"/>	How many hours weekly?
Read books?	<input type="checkbox"/>	<input type="checkbox"/>	How many hours weekly?
Computer games/browsing?	<input type="checkbox"/>	<input type="checkbox"/>	How many hours weekly?
Spiritual/religious practice?	<input type="checkbox"/>	<input type="checkbox"/>	Describe:
Smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	How much?
Smoke cigarettes in the past?	<input type="checkbox"/>	<input type="checkbox"/>	How many years? ____ How many packs? ____
Eat out often?	<input type="checkbox"/>	<input type="checkbox"/>	How many meals per week?
Drink coffee?	<input type="checkbox"/>	<input type="checkbox"/>	How many cups per day?
Drink tea?	<input type="checkbox"/>	<input type="checkbox"/>	How many cups per day?
Drink soda?	<input type="checkbox"/>	<input type="checkbox"/>	How many cups per week?
Eat sugar?	<input type="checkbox"/>	<input type="checkbox"/>	How much?
Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How many alcoholic drinks per week?
Use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	What and how often?
Have an addiction?	<input type="checkbox"/>	<input type="checkbox"/>	To what and how long?
Average 6-8 hours sleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Have a supportive relationship?	<input type="checkbox"/>	<input type="checkbox"/>	
Have a history of abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
Spend time outside?	<input type="checkbox"/>	<input type="checkbox"/>	
Take vacations?	<input type="checkbox"/>	<input type="checkbox"/>	
Enjoy your work?	<input type="checkbox"/>	<input type="checkbox"/>	

What is the major source of stress in your life? \_\_\_\_\_

What is the major source of joy in your life? \_\_\_\_\_

If you have traveled outside of the U.S. in the past 12 months, please detail where you went and when: \_\_\_\_\_

## SYMPTOMS

Please check the box if you have the symptoms currently or if you have had them in the past.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Body heaviness               | <input type="checkbox"/> Excess/low appetite (circle one) | <input type="checkbox"/> Swelling in hands     |
| <input type="checkbox"/> Hard to get up in morning    | <input type="checkbox"/> Excess/low thirst (circle one)   | <input type="checkbox"/> Swelling in feet      |
| <input type="checkbox"/> Muscles often feel tired     | <input type="checkbox"/> Nausea/vomiting                  | <input type="checkbox"/> Lack of taste         |
| <input type="checkbox"/> Energy Level: 1-10 (10=high) | <input type="checkbox"/> Gas/belching                     | <input type="checkbox"/> Chronic loose stool   |
| <input type="checkbox"/> Easy bruising/bleeding       | <input type="checkbox"/> Hemorrhoids                      | <input type="checkbox"/> Abdominal pain        |
| <input type="checkbox"/> Sweetish taste in mouth      | <input type="checkbox"/> Organ prolapse (ie uterus)       | <input type="checkbox"/> Indigestion/heartburn |
| <input type="checkbox"/> Tendency to gain weight      | <input type="checkbox"/> Mouth ulcers                     | <input type="checkbox"/> Brain fog             |
| <input type="checkbox"/> Crave sweet tastes           | <input type="checkbox"/> Over-thinking/worry              | <input type="checkbox"/> Bad breath            |
| <b><u>Spleen/Stomach</u></b>                          |   |  |
| <input type="checkbox"/> Rapid or irregular heartbeat | <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Chest pain            |
| <input type="checkbox"/> Heart palpitations           | <input type="checkbox"/> Low blood pressure               | <input type="checkbox"/> Easily startled       |
| <input type="checkbox"/> Crave bitter tastes          | <input type="checkbox"/> Anxiety/nervous/restless         | <input type="checkbox"/> Red complexion        |
| <input type="checkbox"/> Insomnia/sleep problems      | <input type="checkbox"/> Vivid dreams/nightmares          | <input type="checkbox"/> Dark urine            |
| <b><u>Heart/Small Intestines</u></b>                  |   |  |
| <input type="checkbox"/> PMS/menstrual problems       | <input type="checkbox"/> Visual problems/blurred eyes     | <input type="checkbox"/> Dizziness             |
| <input type="checkbox"/> Feeling of lump in throat    | <input type="checkbox"/> Pain below ribcage               | <input type="checkbox"/> Gall stones           |
| <input type="checkbox"/> Tend to be irritable/angry   | <input type="checkbox"/> Soft/brittle nails               | <input type="checkbox"/> Tendonitis            |
| <input type="checkbox"/> Bitter taste in mouth        | <input type="checkbox"/> Clenching teeth at night         | <input type="checkbox"/> Crave sour tastes     |
| <input type="checkbox"/> Depression/stress            | <input type="checkbox"/> Muscle cramping/twitching        | <input type="checkbox"/> Seizures/tremors      |
| <input type="checkbox"/> Headaches/migraines          | <input type="checkbox"/> Neck/shoulder pain/tightness     | <input type="checkbox"/> Poor circulation      |
| <input type="checkbox"/> Red/dry/itchy eyes           | <b><u>Liver/Gallbladder</u></b>                           |  |
| <input type="checkbox"/> Bloody cough                 | <input type="checkbox"/> Sinus infection/congestion       | <input type="checkbox"/> Snoring               |
| <input type="checkbox"/> Dry cough                    | <input type="checkbox"/> Itchy, red, or painful throat    | <input type="checkbox"/> Bronchitis            |
| <input type="checkbox"/> Chronic cough                | <input type="checkbox"/> Skin rashes, hives               | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Cough with sputum            | <input type="checkbox"/> Shortness of breath              | <input type="checkbox"/> IBS                   |
| <input type="checkbox"/> White nasal discharge        | <input type="checkbox"/> Allergies/asthma                 | <input type="checkbox"/> Diarrhea              |
| <input type="checkbox"/> Yellow nasal discharge       | <input type="checkbox"/> Black or bloody stools           | <input type="checkbox"/> Colitis/spastic colon |
| <input type="checkbox"/> Green nasal discharge        | <input type="checkbox"/> Dry mouth/nose/throat            | <input type="checkbox"/> Low immunity          |
| <input type="checkbox"/> Post nasal drip              | <input type="checkbox"/> Crave pungent or spicy tastes    | <input type="checkbox"/> Catch colds easily    |
| <input type="checkbox"/> Grief/sadness                | <b><u>Lung/Large Intestine</u></b>                        |  |
| <input type="checkbox"/> Bladder infection            | <input type="checkbox"/> Urinary problems (ie night-time) | <input type="checkbox"/> Incontinence          |
| <input type="checkbox"/> Weakness/pain in low back    | <input type="checkbox"/> Feel cold or hot easily (circle) | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> Cold hands/feet              | <input type="checkbox"/> Hair loss/grey hair              | <input type="checkbox"/> Thyroid problems      |
| <input type="checkbox"/> Poor memory                  | <input type="checkbox"/> Hearing problems/tinnitus        | <input type="checkbox"/> Cavities              |
| <input type="checkbox"/> Hot flashes/night sweats     | <input type="checkbox"/> Premature ejaculation            | <input type="checkbox"/> Impotence             |
| <input type="checkbox"/> Crave salt                   | <input type="checkbox"/> Fear                             |  |
| <b><u>Kidney/Urinary Bladder</u></b>                  |   |  |



801 W Main St, Suite #1C  
Bozeman, MT 59715  
Ph. (406) 219-3631  
Fax (406) 760-1809  
www.ElevateHealthMT.com

**CONSENT FOR TREATMENT – ACUPUNCTURE**

I request and give consent to the performance of acupuncture treatment and other procedures within the scope of practice of acupuncture on me (or the person named below, for whom I am legally responsible) by the acupuncturist employed at Elevate Health, LLC.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, gua sha, electrical stimulation, heat, Tuina (Chinese massage), and herbal medicine.

I understand that a series of acupuncture treatments are usually required to significantly change a condition and receive benefit. Some medications and habits are known to lessen acupuncture results. These may include tobacco, alcohol, narcotics, and steroids.

I have been informed that acupuncture is a generally safe method of treatment, but it may have some risks and side effects including numbness, tingling, bruising, bleeding, swelling, fainting, and infection. Minor bruising and bleeding are common and to be expected as the body responds to acupuncture treatment. Burns are possible with some forms of cupping therapy or heat lamps. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, organ puncture including lung puncture (pneumothorax). Herbs and supplements may be associated with allergic reactions. Other side effects and risks may occur with acupuncture, electrical stimulation, herbs and supplements, and manual therapy including cupping and gua sha.

If I suspect that I am pregnant, I will immediately inform the practitioner.

I understand that there may be limitations to the care provided and that I may be referred to another practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the practitioner to anticipate and explain all possible risks and complications, and I permit the practitioner to determine and/or alter the course of treatment which the practitioner judges to be in my best interests based upon the facts then known.

I understand the side effects and potential dangers involved in treatment by means of acupuncture, cupping, gua sha and other supportive modalities. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my condition and for any future conditions for which I seek help.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian/Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Relationship to Patient/Representative Authority