

Welcome to Acupuncture Together. We're glad you're here today!

We rely on word of mouth referrals to grow and sustain our practice. If you have already referred friends, family and/or co-workers here we sincerely appreciate it. Thank you!

We are interested in knowing how you discovered Acupuncture Together. Please check all that apply:

- Cambridge Local First
 - Facebook
 - Google reviews
 - Groupon/Living Social
 - Informative postcard on bulletin board or other display
 - Instagram
 - Nift
 - POCA (People's Organization of Community Acupuncture)
 - Postcard in the mail
 - Web search/our website
 - Word of mouth: friend/family/co-worker
 - Word of mouth: health care provider
 - Yelp reviews
 - Other
-

If it was a word of mouth referral, who can we thank for referring you?

Name:

Health care practice, if applicable:

Thank you!

ACUPUNCTURE TOGETHER CONSENT TO TREAT:

Acupuncture is the stimulation of certain points near the surface of the body by insertion of needles to prevent or modify the perception of pain, normalize physiological functions and treat certain diseases or dysfunctions of the body. While most people find their treatments relaxing and/or energizing, there may be minor side effects, such as slight pain or discomfort at the site of needle insertion, bruises, weakness, fainting, allergic reaction to the metal needles, infection (rarely) or aggravation of symptoms existing prior to treatment.

Herbal medicine means using plant, mineral and animal (rarely) materials to address a myriad of health concerns. Herbal formulas can address issues of the respiratory, nervous, endocrine, reproductive and digestive systems, and side effects may include symptoms in any of these areas.

Please let us know if you are or become pregnant before/during your course of treatment. Acupuncture and herbs are safe during pregnancy as long as your acupuncturist knows and can avoid contraindicated points and herbs. No absolute guarantee can be made about the efficacy of any treatment.

I agree to the above policy:

Print Name: _____

Signature: _____ Date: _____

PAYMENT AND CANCELLATION POLICY:

Payment is due at time of treatment. Cash, checks and credit cards are accepted.

In respect and consideration of others who also need appointments, we ask for 24 hours notice in advance of any appointment cancellation or rescheduling.

Please call the clinic or email us as soon as possible if you need to cancel and/or reschedule, whether or not it is 24 hours in advance.

All appointments that are cancelled with less than 24 hours notice, rescheduled to a later date with less than 24 hours notice and appointments missed with or without notice, will require a missed appointment/late cancellation fee of \$20 to be paid at the time of the next visit.

If appointments have been purchased in a package, then the missed or cancelled appointment will be deducted from the number of remaining appointments in that package.

Thank you for your understanding!

I agree to the above policy:

Print Name: _____

Signature: _____ Date: _____

ACUPUNCTURE TOGETHER HEALTH HISTORY FORM

Name: _____ Today's Date: ____/____/____
(FIRST) (LAST)
Date of Birth: ____/____/____ Age: _____
Address: _____ City: _____ State: _____
Phone: _____ Email: _____
Referred by: _____
Gender: _____ Preferred Pronoun: _____
Occupation: _____ Have you ever been treated by acupuncture? Y / N
Emergency Contact Name & Phone Number: _____

Please complete this questionnaire to the best of your ability. We will discuss your health concerns and review your form during your intake.

MAIN CONCERNS: please write in your top 3 health concerns in order of importance to you. Mark on the scale ranking the severity of the condition from 1-10, with 1 being barely noticeable and 10 being worst ever, and circle the items that make it better or worse. You may also fill in any other unlisted factors that make it better or worse.

1. _____
RANK SEVERITY: 1-----5-----10
When did this start? ____/____ (give month/year to best of ability)
Is it better with (circle): heat cold damp weather exercise rest
Better with other: _____
Is it worse with (circle): heat cold damp weather exercise rest
Worse with other: _____

2. _____
RANK SEVERITY: 1-----5-----10
When did this start? ____/____ (give month/year to best of ability)
Is it better with (circle): heat cold damp weather exercise rest
Better with other: _____
Is it worse with (circle): heat cold damp weather exercise rest
Worse with other: _____

3. _____
RANK SEVERITY: 1-----5-----10
When did this start? ____/____ (give month/year to best of ability)
Is it better with (circle): heat cold damp weather exercise rest
Better with other: _____
Is it worse with (circle): heat cold damp weather exercise rest
Worse with other: _____

HISTORY OF INJURIES/SURGERIES (please note what happened, body area and date or age):

Please list any medications (prescribed and OTC), vitamins or supplements you are currently taking:

MED: _____	PURPOSE: _____
MED: _____	PURPOSE: _____
MED: _____	PURPOSE: _____
MED: _____	PURPOSE: _____
MED: _____	PURPOSE: _____

HABITS:	amount/week	if quit, when?	amount/week	if quit, when?
Coffee/Tea:	_____	_____	Alcohol:	_____
Tobacco:	_____	_____	Drugs:	_____

EXERCISE (type, frequency and amount): _____

CURRENT HEALTH (CIRCLE ALL THAT YOU HAVE EXPERIENCED IN THE LAST MONTH):

Body Temperature: Night sweats Spontaneous day sweats Hot flashes Hot face
Cold hands/Feet Do you tend to feel: Warmer than other people? Colder than other people?

Head: Headaches Migraines Eye pain/strain Eye floaters Dry eyes Itchy eyes Ear ringing
Sinus problems Mouth sores Frequent sore throat TMJ/jaw problems
Seizures/Epilepsy Dizziness/lightheadedness Poor memory Cloudy/foggy-headed

Chest: Palpitations Shortness of breath Asthma Heart disease Low / High Blood Pressure

Thirst: Do you tend to be thirsty? Y / N Prefer cold, neutral or hot drinks?: _____

Skin: Dryness Itching Oily Acne Eczema Psoriasis Roseacea Rashes
Dandruff Hair loss Dry brittle nails Other: _____

Digestion: Poor appetite Excessive hunger Gas Bloating Heartburn Acid reflux
Abdominal pain Belching Nausea Vomiting Bad breath
How often do you have a bowel movement? _____ time(s)/ every _____ day(s)
Hard stool Hard to pass Incomplete stool Loose (not formed) stool Watery stool

Urination: Dark / Light / Clear Scant / Copious Urgent Frequent #times per night: _____

Energy/Immunity: Fatigue Body/limbs feel heavy Tired after eating
Reduced immunity (such as due to HIV, auto-immune disease or chemotherapy)? _____

Sleep: _____ hours/night Hard to fall asleep Hard to stay asleep Restless Tired in A.M.

Emotions: Irritability Depression Anxiety Mood swings Other _____

Female Reproductive: Age of first period: _____ Date of last period: ____/____/____
Length of period: _____ Length of full cycle: _____ Are cycles regular? Y / N
Do you experience: Spotting Clots Heavy flow Light/Scanty flow
Cramps during PMS cramps PMS breast tenderness PMS emotional changes
PMS bloating PMS insomnia PMS other _____
Yeast infections Vaginal dryness Low libido
Are you pregnant? Y / N Total number of pregnancies: _____ Live births: _____
Menopause: Age of last menses: _____ Hot flashes _____x/day Night sweats _____x/week

Male Reproductive: Erectile dysfunction Prostate problems Testicular pain/swelling Low libido

Please list any other concerns you would like to let us know about: _____

