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

We rely on word of mouth referrals to grow and sustain our practice. 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!

(please see other side)

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 PAYMENT OF THE MAXIMUM OF THE SLIDING SCALE AT YOUR 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: ______________________________ (FIRST) (LAST) Today's Date: _____/_____/_____

Date of Birth:_______/_______/_______ Age:_________

Address: ______________________________ City:_____________ State:_____

Phone: ____________________ Email:______________________________

Gender:____________ Pronoun: ______________

Occupation:____________________ Have you ever been treated by acupuncture? Y / N

Emergency Contact Name & Phone: ______________________________

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 see other side)

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: ___________________________
____
____