



**Eagle Rock Community Acupuncture**  
 2042 Colorado Blvd • Los Angeles, CA 90041  
 323-255-2700 • www.ercaclinic.com

**Intake Date:** \_\_\_\_\_

<p><b>PATIENT INFORMATION</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Age: _____ DOB: _____ Gender: _____</p> <p>Preferred Gender Pronouns: _____</p> <p>Occupation: _____</p> <p>Employer/Company Name: _____</p> <p>Primary Physician: _____</p>	<p><b>CONTACT INFORMATION</b></p> <p>Work/Day Phone: _____</p> <p>Home/Evening Phone: _____</p> <p>Cell Phone: _____</p> <p>Email: _____</p> <p>Emergency Contact: _____</p> <p>Relationship: _____</p> <p>Day Phone: _____</p> <p>Evening Phone: _____</p>
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**How did you hear about us?** \_\_\_\_\_

**LIFESTYLE INFORMATION** (Please check that which applies)

<p><b>EXERCISE</b></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Moderate</p> <p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> Heavy</p>	<p><b>WORK ACTIVITY</b></p> <p><input type="checkbox"/> Sitting</p> <p><input type="checkbox"/> Standing</p> <p><input type="checkbox"/> Light Labor</p> <p><input type="checkbox"/> Heavy Labor</p>	<p><b>HABITS</b></p> <p><input type="checkbox"/> Smoking: Packs/Day _____</p> <p><input type="checkbox"/> Alcohol: Drinks/Week _____</p> <p><input type="checkbox"/> Coffee/Caffeine Drinks: Cups/Day _____</p> <p><input type="checkbox"/> High Stress Level: Reason _____</p>
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<p><b>HEALTH HISTORY</b></p> <p>In order of importance, please list your primary concerns for coming in for treatment:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>Please check the symptoms you have:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Fatigue/Tiredness</td> </tr> <tr> <td><input type="checkbox"/> Difficulty focusing</td> <td><input type="checkbox"/> Headaches</td> </tr> <tr> <td><input type="checkbox"/> Dizziness</td> <td><input type="checkbox"/> Loss of sleep/Poor sleep</td> </tr> <tr> <td><input type="checkbox"/> Easily startled</td> <td><input type="checkbox"/> Nervousness/Irritability</td> </tr> <tr> <td><input type="checkbox"/> Excessive worry</td> <td><input type="checkbox"/> Overwhelmed by life</td> </tr> <tr> <td><input type="checkbox"/> Excessive anger</td> <td><input type="checkbox"/> Weight loss</td> </tr> <tr> <td><input type="checkbox"/> Excessive fear</td> <td><input type="checkbox"/> Weight gain</td> </tr> </table>	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue/Tiredness	<input type="checkbox"/> Difficulty focusing	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of sleep/Poor sleep	<input type="checkbox"/> Easily startled	<input type="checkbox"/> Nervousness/Irritability	<input type="checkbox"/> Excessive worry	<input type="checkbox"/> Overwhelmed by life	<input type="checkbox"/> Excessive anger	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Excessive fear	<input type="checkbox"/> Weight gain
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<input type="checkbox"/> Excessive fear	<input type="checkbox"/> Weight gain														

*(For office use only)*

**(over)**

**HEALTH HISTORY CONTINUED...**

List all medications/herbs/vitamins/supplements you are currently taking: \_\_\_\_\_

List major injuries/surgeries/illness: \_\_\_\_\_

Please check conditions you have now or had in the past:

- AIDS/HIV
- Allergies
- Arthritis
- Bleeding disorders
- Breast lumps
- Cancer

Please check the illness that pertains to blood relatives:

- Arthritis
- Blood disorders
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Kidney disease
- Seizures
- Stroke
- Thyroid Disease

When was your last complete medical exam?  
\_\_\_\_\_

**Please check symptoms you have:**

**MUSCLE/JOINT/BONES**

- Tremors or cramps
- Swollen joints

Pain, weakness, or numbness in:

- Arms
- Shoulders
- Neck
- Back
- Legs, Hips
- Hands, Fingers
- Feet, Toes
- Other \_\_\_\_\_

**EYES/EARS/NOSE/THROAT/RESPIRATORY**

- Asthma, Wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Loss of voice
- Gum problems
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

**SKIN**

- Boils
- Bruise easily
- Dry skin
- Sweating
- Itching/Rash
- Sensitive skin
- Non-healing sores
- Acne

**CARDIOVASCULAR**

- Chest pain
- Pain over heart
- Previous heart attack
- Hardening of arteries
- Poor circulation
- Rapid/irregular heartbeat
- Swelling of ankles

**GASTROINTESTINAL**

- Belching, gas, or bloating
- Colon problems
- Constipation
- Diarrhea
- Excessive hunger
- Poor appetite
- Vomiting
- Gallbladder problems
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Difficulty swallowing
- Distention of abdomen

**GENITO/URINARY**

- Blood/Pus in urine
- Frequent urination
- Lowered libido
- Urinary tract infection
- Kidney infection
- Kidney stones
- Inability to control urine

**MALES**

- Erectile dysfunction
- Infertility
- Prostate problems
- Other \_\_\_\_\_
- Premature ejaculation
- STD
- Discharge from penis

**FEMALES**

- Are you pregnant?  Yes  No
- Age of first period: \_\_\_\_\_
- Date of last period: \_\_\_\_\_
- Age of menopause: \_\_\_\_\_
- Color of menstrual flow: \_\_\_\_\_
- Bleeding between periods
- Heavy flow
- Irregular cycle
- Previous miscarriage
- Infertility
- Clots
- Light flow
- PMS
- STD
- Missed Periods

The information on this form is correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## ACUPUNCTURE TREATMENT CONSENT AND AUTHORIZATION

I, the undersigned, hereby authorize **Eagle Rock Community Acupuncture (ERCA)** to administer acupuncture treatments deemed necessary. I understand and have been informed of the possible risks of treatments including but not limited to: *minor bleeding, bruising, minor pain and soreness, as well as the many benefits of acupuncture* and hereby authorize ERCA acupuncturists to provide treatments.

I have been advised that ERCA uses *single-use, sterile disposable acupuncture needles* and that all acupuncture needles are properly disposed of after each and every treatment.

I acknowledge and rely on the acupuncturist's judgment/assessment during the course of the treatment, based on the facts presented, and that my best interest is their priority concern. I recognize and do not expect the acupuncturist to be able to foresee and explain all possible sensations and outcomes that may arise after the treatment and that I have been given the opportunity to discuss the nature and purpose of treatments.

I understand that treatment results cannot be guaranteed and are influenced by many factors including but not limited to: a) acuteness of diagnosis; b) commitment to suggested lifestyle changes; and c) duration/consistency of treatments.

### **CANCELLATION AND REFUND POLICY:**

I acknowledge that all appointments rescheduled or cancelled with less than 24-hours advance notice and missed appointments, will be charged the minimum fee of \$20.00. If treatments have been purchased in a package, the missed, cancelled or re-scheduled appointments shall result in the deduction of one treatment.

I understand and acknowledge that ERCA **has no money-back/refund program** once service has been rendered.

I confirm that I have read and understand the above information, and that I consent to receive acupuncture treatment. I understand that I may refuse treatment or an element of treatment at any time. I acknowledge that no guarantees have been made with regard to the outcome of my treatment(s). I release the practitioners of ERCA from all liability that may occur in connection with the acupuncture treatment/s.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_