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

Intake Date _____

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Age: _____ DOB: _____ Gender:_____

Preferred Gender Pronouns: _____

Occupation: _____

Employer/Company Name: _____

Primary Physician: _____

CONTACT INFORMATION

Work/Day Phone: _____

Home/Evening Phone: _____

Cell Phone: _____

Email: _____

Emergency Contact: _____

Relationship: _____

Day Phone: _____

Evening Phone: _____

How did you hear about us?

LIFESTYLE INFORMATION (Please check that which applies)

EXERCISE	WORK ACTIVITY	HABITS
__ None	__ Sitting	__ Smoking: Packs/Day _____
__ Moderate	__ Standing	__ Alcohol: Drinks/Week _____
__ Daily	__ Light Labor	__ Coffee/Caffeine Drinks: Cups/Day _____
__ Heavy	__ Heavy Labor	__ High Stress Level: Reason _____

HEALTH HISTORY

In order of importance, please list your primary concerns for coming in for treatment:

1. _____

2. _____

3. _____

Please check the symptoms you have:

__ Depression	__ Fatigue/Tiredness
__ Difficulty focusing	__ Headaches
__ Dizziness	__ Loss of sleep/Poor sleep
__ Easily startled	__ Nervousness/Irritability
__ Excessive worry	__ Overwhelmed by life
__ Excessive anger	__ Weight loss
__ Excessive fear	__ 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

MEN ONLY

__ Erectile dysfunction
__ Infertility
__ Prostate problems
__ Other _____
__ Premature ejaculation
__ STD
__ Discharge from penis

WOMEN ONLY

Are you pregnant? __ Yes __ No

Age of first period: _____

Date of last period: _____

Age of menopause: _____

Color of menstrual flow:

__ Light red
__ Purple
__ Bright red
__ Brown
__ Dark Red
__ Black

__ Bleeding between periods
__ Heavy flow
__ Irregular cycle
__ Previous miscarriage
__ Clots
__ Light flow
__ PMS
__ STD

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 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-hour notice and missed appointments, will be charged the minimum fee of **$25.00**. 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 regarding 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: _____