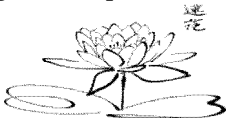
Key Acupuncture



600 E. Washington St. Suite 150
Greenville, SC 29601
(864) 421-0866

Date:_____

Name: _____ Age: _____ Sex: M/F
Address:_____ Birth Date: _____
City: _____ State: _____ Zip Code: _____
Phone number: _____
Preferred contact number:_____
Emergency Contact: _____
E-Mail:_____
Occupation: _____
Referred by: _____
Have you ever had acupuncture? Y / N

What are your chief complaints and how long have you been experiencing these issues? _____
_____
_____
_____
_____
_____

What other treatments have you tried? _____
_____
_____
_____

Medications/Supplements/Vitamins you are currently taking: For what conditions: _____

_____

_____

_____

_____

_____

Medical History (Circle any that apply)

Aids/HIV Alcoholism/Substance Abuse Colitis
Bleed easily Irritable Bowel Syndrome Epilepsy
Kidney Disease Migraines Thyroid Disorder
Hepatitis A / B / C Asthma Allergies Seizures
Migraines Cancer Herpes Pacemaker
Emphysema Lyme's Disease Heart Disease
Diabetes Multiple Sclerosis Pregnant

Other:_____

_____

_____

Please list allergies: _____

_____

_____

Surgeries in the last 10 years: _____

_____

_____

_____

_____

_____

_____

Any food Cravings? _____Intolerances? _____
How many glasses do you drink each day of the following per day?
Water_____ Soda_____ Tea_____ Coffee_____ Alcohol _____
How much do you consume of the following:
Meat_____ Sweets _____Dairy_____
Do you perspire during the day?_____Do you perspire at night?_____
Are you often thirsty? Yes / No

Gastrointestinal: please circle all that pertain:

Belching	Indigestion	Ulcers
Hernia	Nausea	Vomiting
Bloating	Acid Reflux	Hemorrhoids

Bowel movements: How often? day/week _____

Irregularity	Constipation	Diarrhea/ Gas

Exercise and Energy:
What kind of exercise do you do? _____
How often? _____
How is your energy level? _____

Emotions and Sleep:

Panic Attacks	Depression	Anxiety
Nervous	Fearful	Poor Memory
Difficulty falling asleep	Waking up in the night	

Urination:
Is your urine light or dark in Color? _____
Frequent Bladder Infections? y/n
Frequent Urination? y/n
Do you wake up at night to urinate? y/n
Pain during urination? y/n

Gynecology: (Women's Health)
Age Menses Began: _____ Days of menstrual flow: _____
Length of cycle (day 1 to day 1): _____
Number of Pregnancies: _____ Number of live births: _____
Age at Menopause: _____
Heavy flow Light flow No flow Blood clots PMS
Painful periods Irregular Period Uterine fibroids

Men's Health
Last prostate check-up_____ Results/PSA count _____
How is your libido? _____
Impotence, erectile dysfunction? y/n

Respiratory:
Do you smoke? y / n _____#cigarettes /day for years
Frequent Colds Asthma Cough Cold Sores
Bleeding Gums Dry mouth Migraine Ringing in Ears
Sinusitis

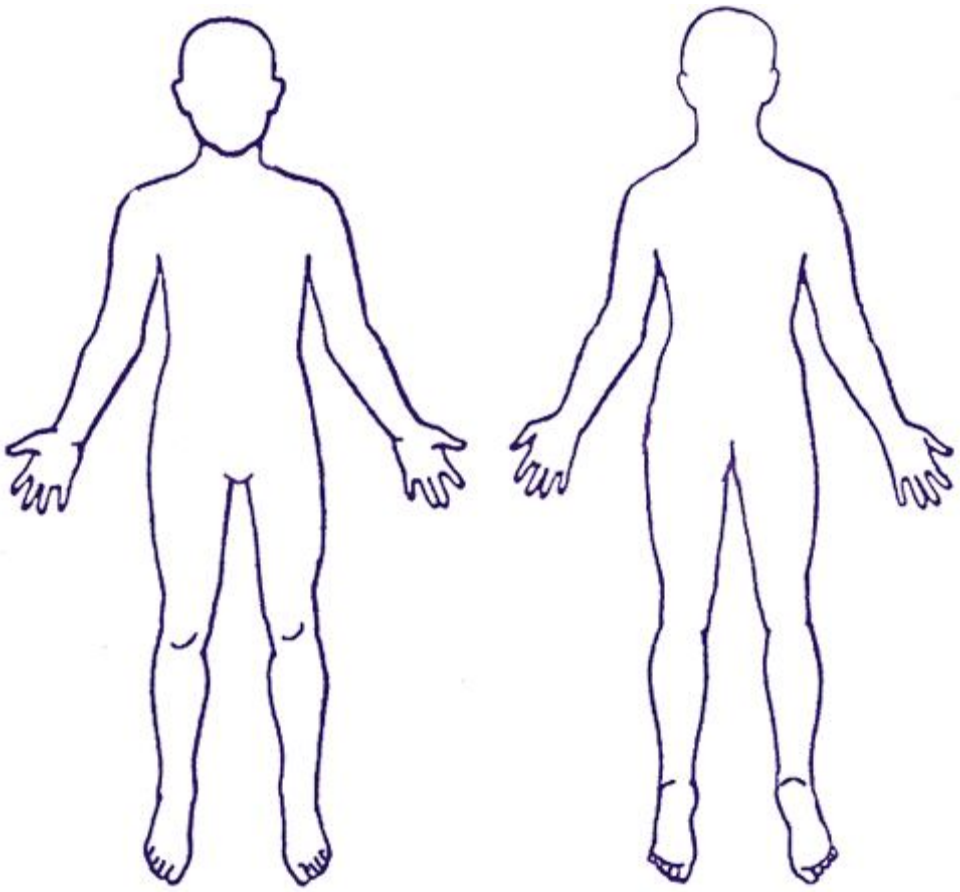
Cardiovascular:
Palpitations Varicose Veins Cold hands/feet
Poor circulation Dizziness Chest pain
Irregular heart beat High blood pressure Low blood pressure

Skin and Hair:
Dry skin Skin rashes Itching
Acne Eczema Hair loss

Musculoskeletal:

Joint pain Arthritis Muscle tightness Numbness
Tendonitis Osteoporosis Swelling

Mark with an (X) where you are feeling any discomfort or pain.



Place a circle around a number to indicate average pain level in the last week.

0 1 2 3 4 5 6 7 8 9 10
(No pain) (Extreme Pain)

What makes the pain better? (Circle all that apply)
Heat cold movement massage rest

Key Acupuncture

Consent Form
And
Privacy Policy

I hereby consent to the following provisions deemed necessary by Kathryn Youngs, L.Ac. (Licensed Acupuncturist/Acupuncture Physician)
Patient's Name

_____

Treatment:
Any and all healthcare and treatment, which may include acupuncture, herbal formulas, cupping, therapeutic exercises, nutritional counseling and e-stem. I understand that needling and cupping therapy may cause slight bruising.

Privacy:
Under HIPPA privacy act, your treatment and any information discussed while receiving treatment in this office will remain confidential.

Financial Information:
All fees are due at the time services are rendered.
Upon request, documentation will be provided for insurance reimbursement.

I have read, understand and agree to information stated above.
Signature: _____
Date: _____

For Practitioner Use

Progress Notes

Patients Name: _____

Age:_____Sex: M/F Date: _____

Chief Complaints:

_____

_____

_____

_____

Secondary Complaints:

_____

_____

_____

_____

Emotions: _____

Digestion:_____

Energy: _____

Sleep: _____

Temperature/sweats:_____

Menses:_____

Tongue: _____

Pulse: _____

Diagnosis: _____

Treatment: Front Back Side

Cupping _____ Stim: _____

Herbal Recommendation:_____

_____