unwind
acupuncture | massage
4685 s. ash avenue, h1 | tempe, az 85282
480.620.8268

new patient information | confidential

name _____ date_____

address _____ city _____ state _____ zip _____

cell phone _____ home phone _____ work phone _____

email _____

date of birth _____ marital status _____ # of children _____ age(s) _____

occupation _____ employer _____

highest level of education completed: ☐ high school ☐ bachelors ☐ masters ☐ doctorate ☐ professional

emergency contact _____ emergency number _____

primary care physician _____ date of last visit _____

height _____ weight _____ age _____ gender: ☐ male ☐ female

have you had acupuncture before? ☐ yes ☐ no

major complaint(s), in order of **importance to you**:	date of onset	severity (1-10 / 10=severe)
1.		
2.		
3.		

are you currently being treated for any of the above conditions by anyone else? ☐ yes ☐ no

if yes, who _____

has this condition been diagnosed by a Medical Doctor? ☐ yes ☐ no diagnosis: _____

how did you hear about **unwind | acupuncture + massage**? ☐ friend / relative ☐ internet ☐ brochure ☐ special event

if you were referred by a friend, who may we thank for the referral? _____

i wish to be contacted in the following manner (check all that apply):

☐ cell phone
☐ home phone
☐ work phone
☐ email

Unwind | Acupuncture + Massage does not release protected health information and/or sensitive health information over the phone, via electronic mail, or via written communication without patient written authorization. If we need to communicate protected health information to you we will contact you to schedule a consultation appointment.

From time to time we may phone, email or post general information such as updates and alerts, notification of specials and reminders of upcoming appointments.

Unwind | Acupuncture + Massage will never sell or distribute your contact information. Your contact information is for internal use only.

health + lifestyle inventory

what activities/hobbies do you enjoy? _____

what types of exercise do you do? _____

how would you rate your current stress level? ☐ extreme ☐ very high ☐ high ☐ moderate ☐ low

how would you rate your energy level on a scale of 1 -10? (10 being highest) _____

hours of sleep per night: _____ do you feel rested upon waking? _____

do you have any known or suspected allergies? ☐ yes ☐ no (list)_____

please list any medications and supplements you are currently taking:

drug/supplement	reason for taking	how long?	dose	frequency

are you currently taking coumadin, warfarin or heparin? ☐ yes ☐ no are you taking plavix / aspirin? ☐ yes ☐ no

surgical / injury history:

surgery / injury / accident	date	please give a brief description

are you...

on a restricted diet? ☐ yes ☐ no

a vegetarian? ☐ yes ☐ no

a vegan? ☐ yes ☐ no

on a raw food diet? ☐ yes ☐ no

do you have any food cravings?

check all that apply...

☐ sweet ☐ spicy ☐ sour

☐ salty ☐ bitter ☐ crunchy

☐ hot ☐ cold ☐ dairy

☐ other: _____

what is your daily intake of the following?

water _____

coffee _____

soda _____

other _____

do you currently...

smoke?

☐ yes ☐ no

use recreational drugs?

☐ yes ☐ no

consume alcohol?

☐ yes ☐ no

have an infectious disease?

☐ yes ☐ no if yes describe:

_____

medical history | check all that apply

eyes, ears, nose, throat
- ☐ impaired vision
- ☐ eye pain / strain
- ☐ glaucoma
- ☐ glasses / contacts
- ☐ tearing / dryness
- ☐ floaters in the eyes
- ☐ impaired hearing
- ☐ ear ringing
- ☐ earaches
- ☐ headaches
- ☐ sinus problems
- ☐ nose bleeds
- ☐ teeth grinding
- ☐ sore throat
- ☐ TMJ / jaw problems
- ☐ hay fever

cardiovascular
- ☐ i have a pacemaker
- ☐ heart disease
- ☐ heart attack
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chest pain
- ☐ palpitations
- ☐ stroke
- ☐ varicose veins
- ☐ edema

respiratory
- ☐ pneumonia
- ☐ asthma
- ☐ frequent colds
- ☐ difficulty breathing
- ☐ emphysema
- ☐ persistent cough
- ☐ pleurisy
- ☐ tuberculosis
- ☐ shortness of breath

gastrointestinal
- ☐ stomach ulcers
- ☐ changes in appetite
- ☐ nausea / vomiting
- ☐ abdominal pain
- ☐ gas
- ☐ heartburn
- ☐ belching
- ☐ gall bladder disease
- ☐ hemorrhoids
- ☐ colitis / diverticulitis
- ☐ constipation
- ☐ diarrhea
- ☐ irritable bowel syndrome
- ☐ leaky gut syndrome

reproductive
- ☐ low libido
- ☐ excessive libido
- ☐ painful intercourse
- ☐ PMS
- ☐ clotting
- ☐ heavy flow
- ☐ scanty flow
- ☐ spotting
- ☐ irregular cycles
- ☐ vaginal discharge
- ☐ menopausal symptoms
- ☐ endometriosis
- ☐ fibroids
- ☐ infertility
- ☐ breast lumps
- ☐ nipple discharge
- ☐ abnormal pap smear
- ☐ hysterectomy
- ☐ i am taking birth control

neurological
- ☐ vertigo / dizziness
- ☐ paralysis
- ☐ numbness / tingling
- ☐ loss of balance
- ☐ seizures / epilepsy
- ☐ dyslexia
- ☐ insomnia
- ☐ poor memory

emotional / mental
- ☐ anxiety / fear
- ☐ anger / frustration
- ☐ grief / sadness
- ☐ lack of joy / mania
- ☐ worry / over-thinking
- ☐ depression
- ☐ ADD or ADHD
- ☐ panic attacks
- ☐ alzheimer's / dementia

musculo-skeletal
- ☐ neck / shoulder pain
- ☐ muscle spasms / cramping
- ☐ back pain
- ☐ arm pain
- ☐ leg pain
- ☐ tendonitis
- ☐ bursitis
- ☐ osteoporosis
- ☐ arthritis
- ☐ joint pain

genito - urinary tract
- ☐ kidney disease
- ☐ kidney stones
- ☐ painful urination
- ☐ dribbling urination
- ☐ frequent UTI
- ☐ frequent urination
- ☐ blood in urine
- ☐ discharge
- ☐ incontinence

energy / immunity
- ☐ general fatigue
- ☐ slow wound healing
- ☐ easy bruising
- ☐ chronic infections
- ☐ frequent allergies

endocrine
- ☐ hypothyroid
- ☐ hypoglycemia
- ☐ hyperthyroid
- ☐ diabetes: type 1
- ☐ diabetes: type 2
- ☐ night sweats
- ☐ unusual sweating
- ☐ feeling hot or cold

men only
- ☐ impotence
- ☐ seminal emissions
- ☐ testicular pain / swelling
- ☐ prostate problems
- ☐ low libido
- ☐ excessive libido
- ☐ painful intercourse
- ☐ vasectomy

date: _____

family history
- ☐ asthma
- ☐ obesity
- ☐ cancer
- ☐ stroke
- ☐ diabetes
- ☐ hypertension
- ☐ heart disease
- ☐ other:

_____

please answer the following questions if you are experiencing pain...

date you first began to experience the pain: _____

cause of the pain: ☐ injury/accident ☐ disease ☐ unknown

quality of pain:

☐ dull ☐ sharp ☐ stabbing ☐ sore ☐ cramping

☐ fixed ☐ constant ☐ burning ☐ moves around

what helps to alleviate the pain?

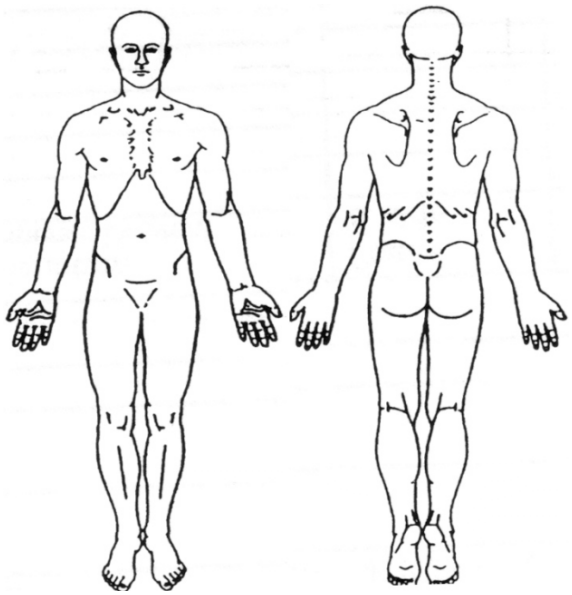
☐ ice ☐ heat ☐ pressure ☐ rest ☐ movement

☐ moisture ☐ massage ☐ nothing ☐ other: _____

what aggravates the pain?

☐ ice ☐ heat ☐ pressure ☐ rest ☐ movement

☐ moisture ☐ massage ☐ nothing ☐ other: _____



please indicate on the diagram the areas where you are experiencing pain

is there anything else you wish to add? _____

_____

the above information is true to the best of my knowledge. i understand and accept that i am responsible for full payment of my account and that payment is expected at the time of service. i also understand that i may ask my practitioner for a more detailed explanation of anything regarding my treatment. i understand that my records will be kept confidential and will not be released without my written consent (unless in a medical emergency or by legal demand). i give my permission and consent to treatment.

signature: _____ date: _____

parent / guardian (if applicable): _____

practitioner signature: _____

please check if you have had any of the following conditions:

☐ fibromyalgia ☐ lupus

☐ candida ☐ lyme disease

☐ anemia ☐ rash / hives

☐ eczema ☐ hemophilia

☐ alcoholism ☐ AIDS / HIV

☐ chicken pox ☐ measles

☐ mumps

☐ cancer: _____

women only:

are you pregnant?

☐ yes ☐ no ☐ maybe ☐ trying

if yes, how far along are you?_____

please list the number of:

pregnancies _____

births _____

abortions _____

miscarriages _____

start date of last period:

_____

typical length of period:

_____

typical length of cycle (day 1 to day 1):

_____

menopause (date):

_____

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By signing below, I do hereby voluntarily consent to be treated with acupuncture and Oriental medicine by a Licensed Acupuncturist at Unwind / Acupuncture + Massage. I understand that acupuncturists practicing in the state of Arizona are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

***Initial here*_____ Acupuncture / Moxibustion:** I understand that acupuncture is performed by the insertion of single use sterile needles through the skin, by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

***Initial here*_____ Pregnancy:** I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Initial here*_____ Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, ***there will likely be burning or scarring the skin from its use. In fact, burning and scarring may even be a part of the therapeutic action, and may be intentional, on the part of the practitioner. I understand that I may refuse this therapy.

***Initial here*_____ Acupressure / Tui-Na Massage:** I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Initial here*_____ Cupping / Gua Sha:** I understand that I may also be given cupping (the application of glass or plastic cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful. However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

***Initial here*_____ Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect Becky Coatsworth or the Unwind / Acupuncture + Massage. LLC staff to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

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