Dr. Leslie Deems
Functional Medicine
leslie@awakenbalance.com
(510) 846-8451

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Address: _____ City: _____ State: ___ Zip: _____

Phone #: _____ Email: _____ Referred by: _____

Date of Birth: _____/_____/_____ Age: _____ Gender Preference: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Have you ever had acupuncture before? Yes No Do you have a pace maker? Yes No

Do you have any surgical implants? Yes No Are you pregnant? Yes No

Height: _____ Weight: _____

Are you presently taking any medication, herbs, homeopathic remedies, supplements? Yes No

Please list: _____

_____

_____

Please list any allergies that you may have (drugs, food, chemicals): _____

_____

_____

When and where did you last receive health care? _____

For what reason? _____

Present Condition:

Please identify the health concerns that have brought you to this clinic in order of importance below:

Chief Complaint (1) _____

Date of Onset:____/___/_____ Is your condition: □ Getting Worse □ Constant □ Intermittent

How does this condition affect you?_____

What makes it better? _____ What makes it worse? _____

Do you have a western medical diagnosis for this condition? Y/N _____

Level of Pain on a scale of 1-10 (10 being severe pain): _____

2)_____

Date of Onset:____/___/_____ Is your condition: □ Getting Worse □ Constant □ Intermittent

How does this condition affect you?_____

What makes it better? _____ What makes it worse? _____

Do you have a western medical diagnosis for this condition? Y/N _____

Level of Pain on a scale of 1-10 (10 being severe pain): _____

3)_____

Date of Onset:____/___/_____ Is your condition: □ Getting Worse □ Constant □ Intermittent

How does this condition affect you?_____

What makes it better? _____ What makes it worse? _____

Do you have a western medical diagnosis for this condition? Y/N _____

Level of Pain on a scale of 1-10 (10 being severe pain): _____

Immunizations (please circle any that you have had):

Tetanus_____ Hepatitis B_____ HPV/Gardisil _____ Covid _____x_____ Flu _____x_____

Hospitalizations and Surgeries:

Reason: _____ Date:___/____/_____

Reason: _____ Date:___/____/_____

Reason: _____ Date:___/____/_____

How often do you have a bowel movement? _____

What is the consistency?	Firm/Normal	Toothpaste	Watery	Hard/Difficult to Pass
What do your stools resemble?	S Shape	Long & Thin	Undigested Food	Goat Stool

Lifestyle

How many hours per night do you sleep? _____ Do you wake feeling rested? Y/N

What is your Exercise Routine? _____

Are you a vegetarian? Y/N Are you a vegan? Y/N How many meals do you eat per day? ____

Occupation: _____ How many hours per week do you work?_____

Do you enjoy your work? Y/N Do you smoke? Y/N How often? _____ Do you drink alcohol? Y/N

How often? _____Caffeine Use? _____ Water Intake _____Interests/

Hobbies: _____

Treatment Information

Pre-Treatment Considerations: Please eat an adequate amount of food before your treatment. You should not receive acupuncture with an empty or overly full stomach.

Post-Treatment Care: If you receive treatments for pain, avoid aggravation of the painful area between treatments. It is recommended to "baby" that area and avoid strenuous or aggravating activity as much as possible in order to receive maximum benefits. Following your treatment, your body makes adjustments for up to 36 hours. There is a 10% chance that you may experience an aggravation of the condition that you are being treated for. There is no cause for concern, as this is a healing response to the effective and unique treatment employed. The pain/discomfort and usually subsides within 36 to 48 hours. Typically, the pain will then subside to a lower level than before the treatment.

Treatment Progression and Recovery: Acupuncture treatments stimulate your body's own healing capacity. Therefore, the progress of your healing will follow a natural course. As this occurs, you are likely to experience a reoccurrence of the pain/condition in between your treatments to some degree. The degree of pain, if not aggravated, progressively decreases over a series of treatments. Finally, the pain will decrease to the level where the condition has recovered. The individual time for recovery will be different from patient to patient.

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other modalities within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Leslie Deems, L. Ac. or other licensed acupuncturists who now or in the future treat me while serving as her substitute.

I understand that methods of treatment may include acupuncture with sterile and disposable needles, Tui-Na massage, cupping, Chinese herbal medicine and nutritional counseling. I understand that acupuncture is a safe method of treatment, but side effects may include bruising or tingling near the needling sites, dizziness or fainting.
Extremely rare risks include nerve damage, organ puncture and spontaneous miscarriage.

The herbs prescribed are considered safe in the practice of Oriental medicine. I understand that the herbs prescribed and given by the acupuncturist must be taken according to the practitioner's instruction only. I agree to inform the acupuncturist about any other herbs, medications or supplements that I am taking currently or during future courses of treatments. The herbs prescribed may have a strong medicinal taste. Occasional side effects may include digestive upset or allergic reactions. If any discomfort is noticed while taking the prescribed herbs, I understand to discontinue use and notify the office immediately. I understand that some herbs may be inappropriate during pregnancy. I agree to inform the acupuncturist if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist considers at the time, based upon the facts then known, and is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above "treatment information" and "informed consent." I have also had an opportunity to ask questions about the content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE _____ Date _____/_____/_____
(or patient representative)

Financial Policy

Thank you for choosing our acupuncture office as your health care provider. The following is a statement of our Financial Policy, which we require that you read, and sign prior to treatment. We are happy to provide you with a copy for your records.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN WRITING PRIOR TO TREATMENT. Our office accepts cash & checks. All returned checks will incur a $25.00 (twenty-five) dollar fee, which will automatically be charged to your account.

Minor Patients

Minor children must be accompanied by a parent or guardian for all treatment. The parent or guardian is responsible for payment.

Missed Appointments

Unless cancelled at least 24 (twenty-four) hours in advance, our policy is to charge a $50.00 (fifty) dollar fee for a missed appointment. Please help us serve you better by keeping scheduled appointments.

Please let us know if you have any questions or concerns.

I have read the above Financial Policy. I understand and agree to the terms stated above.

_____ _____/_____/_____

Signature of Patient or Responsible Party Date