Intake Form: Personal History

Name:_____

Date: _____

Age_____ Birth date _____ Pronouns_____

Address_____

City_____ State _____ Zip _____

Phone (home)_____(work)_____ (cell)_____

E-mail _____

Occupation _____Full-time/Part-time _____Retired____

Employed by_____

Education_____

In your opinion, what are your most important health problems? List as many as you can in order of importance:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Past Medical History:

What childhood illnesses have you had?

____ Rubella (3 day-measles) ____ Mumps ____ Chickenpox
____ Measles (2 weeks) ____ Whooping Cough ____ Asthma
____ Scarlet Fever ____ Rheumatic Fever

Did you suffer from recurring: ____Coughs/chest infections ____ Ear infections
____ Tonsillitis/throat infections ____ Stomach aches
Any other illnesses _____

Please state (if known) the health of your mother when she was pregnant with you. Did she suffer from:

____anemia ____toxemia
____diabetes ____emotional trauma
____high blood pressure ____physical trauma

During pregnancy, did your mother take any medications, use recreational drugs/alcohol, etc? Were there any problems during the pregnancy?

_____

_____

Was your own birth:

____normal ____premature
____long ____Cesarean
____difficult ____forceps or breach

Were there any problems with your development as an infant or child? Teething, crawling, talking, etc? Please list:_____

Did you have any reactions to any vaccinations?_____

Your Health History:

Now	Past		Now	Past	
____	____	Addictions	____	____	Diabetes
____	____	Alcohol	____	____	Epilepsy
____	____	Allergies	____	____	Gout
____	____	Anemia	____	____	Heart Condition
____	____	Anorexia	____	____	Hepatitis
____	____	Asthma	____	____	Kidney Disease
____	____	Bleeding	____	____	Liver Disease
____	____	Bruising	____	____	Mental Disease
____	____	Bulimia	____	____	Migraines
____	____	Cancer	____	____	Obesity
____	____	Colitis	____	____	Pneumonia
____	____	Depression	____	____	Rheumatism
____	____	Drugs	____	____	STD
____	____	Thyroid	____	____	Tuberculosis

Other:_____

Hospitalizations: List as best as you can

Type of illness/operation Date:

_____ _____

_____ _____

_____ _____

Accidents:

Please give details of any serious falls/burns/broken bones/injuries/etc:

_____

_____

Do You Use:

Yes	Amount	Yes	Amount
____ Coffee	_____	_____ Birth Control Pills	_____
____ Cigarettes	_____	_____ Sedatives/Tranquilizers	_____
____ Alcohol	_____	_____ Thyroid medicine	_____
____ Painkillers	_____	_____ Laxatives	_____
____Other Drugs	_____	_____ Cortisone	_____

*Please list all medications (including herbal, homeopathic and vitamin/mineral supplements) that you are currently taking. Also a list of all homeopathic remedies and the major orthodox medications you have taken up to date.

Family History:

Mother: Age if alive _____ OR Age at death_____ Occupation _____

Overall health _____

Specific problems (in childhood and as an adult) _____

_____

Father: Age if alive _____ OR Age at death_____ Occupation _____

Overall health _____

Specific problems (in childhood and as an adult) _____

_____

Immediate Family History: Brothers/Sisters/Grandparents, etc.

Please check below if you know (or can find out) if any of the following have occurred in your immediate family:

____ Alcoholism ____ Arthritis/Rheumatism/Gout
____ Asthma ____ Cancer ____ Diabetes
____ Eczema ____ Epilepsy ____ Skin problems
____ Hay fever ____ Warts ____ Heart problems
____ High blood pressure/angina/strokes/etc
____ Hernia ____ Herpes (oral/genital)
____ Jaundice/Hepatitis ____ STDs
____ Tuberculosis ____ Mental illness (incl. suicides)

Please list if there are any common diseases, mental illnesses, or addictions, or ailments in your family history:

_____

_____

_____

_____

_____

_____

Acknowledgment and Waiver of Liability

I, _____, hereby acknowledge and agree as follows:

I accept full responsibility for my health and voluntarily complete this Acknowledgment and Waiver of Liability.

I acknowledge that I am seeking the consultation and treatment services of Elizabeth Astor, LAc. for the modalities she has trained in that are part of her practice of Acupuncture, Chinese Herbal Medicine and Classical Homeopathy. I am also am consenting to receive alternative healing suggestions and therapies, which I fully understand are not allopathic medical diagnoses or treatments, and that they are not substitutes for medical diagnoses or treatments. I understand that acupuncturists and homeopaths practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. In seeking to become a client of Elizabeth Astor, LAc., I understand that I am seeking analyses and/or therapies that may not be FDA registered or approved and which may be considered experimental. These include, but are not limited to Herbal Medicine, Nutrition guidance, Nutraceuticals, Coaching, Akashic Record Consulting, Homeopathy, Flower Essences, Essential Oils, and Energy Balancing techniques included in Intuitive Healing.

I agree that if I am taking any medications while under treatment with Elizabeth Astor that I will inform her of all such medications and will notify her immediately in the event that there are any changes in my medications. I also understand that if I become pregnant or are nursing that I will notify her immediately, due to the fact that some herbs, etc. are contraindicated in these conditions. I confirm that any prescriptions/medications I am taking under the care of a physician will not be withdrawn without his/her supervision.

I hereby request and consent to the performance of acupuncture and other complementary medicine procedures on me by Elizabeth Astor, LAc. I understand that these methods or treatment may include, but are not limited to: Acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na, Chinese or Western Herbal Medicine, supplement recommendations, nutritional counseling, homeopathy, essential oils, flower essences, energetic medicine and intuitive healing.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) 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. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, nerve damage, 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 Elizabeth will stop any treatment at any time, per my request.

Chinese Herbs/Homeopathy/Supplements: I understand that substances from the Chinese and Western materia medica, nutraceuticals, and homeopathics may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Some herbs are inappropriate for pregnancy. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Essential Wellbeing Clinic as soon as possible.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment. 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 end any treatment at any time with a verbal request to Elizabeth.

Electro-Acupuncture: I understand that I may be offered 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.

Intuitive Healing and Akashic Records Consultations: I understand that the consultation provided by Elizabeth is intended to provide general and inner developmental information only and is not intended as medical advice nor is it intended for psychiatric or psychological evaluation, diagnosis, or treatment. Elizabeth Astor disclaims any liability arising directly or indirectly from any information given or received in this consultation.

I have carefully read and understand all of 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. I give my permission and consent to treatment.

Cancellation Policy: I understand that a block of time has been set aside for my private appointment, and that a 24-hour notification is required if I must cancel. I understand that there is a full charge for appointments canceled less than 24 hours in advance. I understand that payment is due by check, credit card or cash at the time services are rendered, unless other arrangements have been made prior to the appointment.

UNDERSTOOD, ACCEPTED AND AGREED

Date: _____

Client's Signature: _____

Client's Name (print): _____
(State relationship if signing on behalf of client)

Essential Wellbeing

Acupuncture | Chinese Herbal Medicine | Homeopathy

Elizabeth Astor, L.Ac., MSOM, Dipl. OM, CHom
3450 Penrose Place, Suite 240
Boulder, CO. 80301

www.essential-wellbeing.com
info@essential-wellbeing.com
Phone: 720.722.0111

Education and Experience

Elizabeth Astor earned her Master of Acupuncture and Oriental Medicine degree from Southwest Acupuncture College in 2011. This four-year program consists of 3,500 hours of education, including 1,000 hours of clinical practice. She was certified as a Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September 2011. This includes certification in Clean Needle Technique and Chinese Herbology. Elizabeth's training includes adjunctive therapies such as herbology, moxibustion, tui-na, acupressure, cupping, auriculotherapy, Intuitive healing, and dietary and lifestyle recommendations. Elizabeth received her professional practitioner certification in Classical Homeopathy (CHom) in 2009 from the Homeopathy School International. This two-year program consists of 500 hours of education including 250 hours of clinical casework.
Elizabeth is a member of the Acupuncture Association of Colorado and the American Association of Oriental Medicine. She is a licensed acupuncturist in Colorado. None of these licenses, certificates, or registrations has ever been suspended or revoked. This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.

___(Initial) I agree to receive text messages to this mobile phone number (____)_____ reminding me about my upcoming appointments with Essential Wellbeing. I understand that SMS reminders are optional and that message and data rates may apply. Email reminders are also available.

_____

Patient or Guardian's Signature Date