**Acupuncture center**

4701 College Boulevard, Suite 206

Leawood, KS 66211

(913)642.7200

[www.doctoryoo.net](http://www.doctoryoo.net)

**Patient Information**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_Male \_\_\_\_\_ Female \_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work or Mobile Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main problem you would like to address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was there an accident or incident? \_\_\_\_\_\_\_

If yes, please describe; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition getting worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it constant or intermittent (please circle)

Is it worse with certain activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, with which activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please describe your pain;**

\_\_\_ Sharp \_\_\_ Tingling \_\_\_ Dull \_\_\_ Throbbing

\_\_\_ Burning \_\_\_ Cramp \_\_\_ Stiff \_\_\_ Shooting

\_\_\_ Other

**Does this condition interfere with your;**

\_\_\_ Work \_\_\_ Sleep \_\_\_ Exercise

\_\_\_Daily Routine \_\_\_ Recreation \_\_\_ Meals

Have you sought previous treatment for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment was administered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Medication - Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Chiropractic

\_\_\_ Surgery

\_\_\_ Physical Therapy

\_\_\_ Other

Have you recently had;

\_\_\_ Physical Exam \_\_\_ Spinal Exam \_\_\_ Spinal X-Ray

\_\_\_ Blood Work \_\_\_ MRI,CT, Scan \_\_\_Other X-rays

\_\_\_ Urine Test \_\_\_ Pregnancy Test - Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you have had any of the following;

\_\_\_ AIDS \_\_\_ Heart Disease \_\_\_ Psychosis

\_\_\_ Alcoholism \_\_\_ Hepatitis \_\_\_ Rheumatitis

\_\_\_ Allergy Shots \_\_\_ Hernia \_\_\_ Scarlet Fever

\_\_\_ Anemia \_\_\_ Hemophilia \_\_\_ Stroke

\_\_\_ Anorexia \_\_\_ Kidney Disease \_\_\_ Suicide Attempt

\_\_\_ Appendicitis \_\_\_ Liver Disease \_\_\_ Thyroid Condition

\_\_\_ Arthritis \_\_\_ Measles \_\_\_ Tonsilitis

\_\_\_ Asthma \_\_\_ Migraines \_\_\_ Tuberculosis

\_\_\_ Breast Lump \_\_\_ Miscarriages \_\_\_ Tumors, Growths

\_\_\_ Bronchitis \_\_\_ Mononucleosis \_\_\_ Typhoid Fever

\_\_\_ Bulimia \_\_\_ MS \_\_\_ Ulcers

\_\_\_ Cancer \_\_\_ Mumps \_\_\_ Vaginal Infections

\_\_\_ Cataracts \_\_\_ Osteoporosis \_\_\_ Venereal Disease

\_\_\_ Chemical Dependency \_\_\_ Pacemaker \_\_\_ Whooping Cough

\_\_\_ Chicken Pox \_\_\_ Parkinson’s Disease \_\_\_ Epilepsy

\_\_\_ Cholesterolemia \_\_\_ Pinched Nerve \_\_\_ Polio

\_\_\_ Diabetes \_\_\_ Pneumonia \_\_\_ Fractures

\_\_\_ Prosthesis \_\_\_ Glaucoma \_\_\_ Cysts

\_\_\_ Goiter \_\_\_ Prostatitis \_\_\_ Gonorrhea

\_\_\_ Other

**Exercise: Work Activity: Habits:**

\_\_\_ None \_\_\_ Sitting \_\_\_ Smoking

\_\_\_ Moderate \_\_\_ Standing \_\_\_ Alcohol Use

\_\_\_ Daily \_\_\_ Light Labor \_\_\_ Caffeine Use

\_\_\_ Heavy \_\_\_ Heavy Labor \_\_\_ High Stress Level

**Injuries and/or surgeries:**

Head Injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fractures or dislocations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Personal Medical History**

## Significant Illnesses

Cancer Seizures Diabetes Rheumatic Fever

Hepatitis Heart Disease Thyroid Disease Stroke

HIV (AIDS) Weight Problem Venereal Disease Mental Illness

Allergies Tuberculosis Addictive Disorders Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma Herpes High Blood Pressure

***Please check if you have experienced any of the following in the last 3 months.***

**General**

Poor Appetite Localized Weakness Peculiar Tastes or Smells Sweat Easily

Fevers Insomnia Bleeding Change in Appetite

Fatigue Strong Thirst Weight Loss Night Sweats

Tremors Poor Balance Weight Gain Depression

Cravings Chills Join Pain Emotional Changes

Headaches Sudden Energy Drop Hearing Loss Bruising Easily

### Skin & Hair

Rashes Itching Change in Skin Texture Ulcers

Eczema Hair Loss Dandruff Acne

Recent Moles Change in Hair Texture Hives Psoriasis

### ENT + Head & Eyes (HEENT)

Dizziness Eye Pain Earaches Migraine Recurrent Sore Throat

Ringing in Ears Glasses Glaucoma Eye Strain Sores on Lips

Gum Problems Sinus Problems Poor Vision Teeth Grinding Sores on Lips

Night Blindness Headaches Cataracts Floaters Mouth Ulcers

Facial Pain Blurred Vision Concussion Spots in front of Eyes

Color Blindn ess Jaw Click Poor Hearing Nose Bleeds Toothache

**Respiratory:**

Cough Coughing Blood Phlegm Shortness of Breath Painful Breathing

Wheezing Bronchitis Asthma Easily Winded

### Cardiovascular

Blood Clots Fainting Cold Hands or Feet Low Blood Pressure

Phlebitis Dizziness Swelling of Hands Shortness of Breath

Chest Pain Swelling of Feet Irregular Heartbeat Difficult Breathing

### Gastrointestinal

Nausea Bloating Blood in Stools Abdominal Pain

Belching Constipation Black Stools Vomiting

Diarrhea Hemorrhoids Bad Breath Gastric Ulcers

Indigestion Parasites Intestinal Gas

### Genito/Urinary

Painful Urination Urgent Urination Scanty Urination Frequent Urination

Blood in Urine Impotence Unable to Hold Urine Frequent Night Urination

Genital Sores Kidney Stones Discolored Urine

**Gynecology & Pregnancy (females only)**

Irregular period Duration of Flow \_\_\_\_\_\_ # of Pregnancies\_\_\_\_ Difficult Births \_\_\_\_\_\_

Clots Painful Periods # of Births\_\_\_\_ Fertility Problems

Light Flow Age of First Menses \_\_\_\_ # of Miscarriages \_\_\_\_ Breast Lumps

Heavy Flow Date of Last Menses \_\_\_\_\_ # of Abortions\_\_\_\_ Vaginal Discharge

PMS Last PAP \_\_\_\_\_\_\_\_\_\_\_\_\_ # of Premature Births\_\_\_ Vaginal Sores

**Personal Medical History**

## Significant Illnesses

### Neuro-Psychological

Seizures Areas of Numbness Concussion Loss of Balance

Dizziness Lack of Coordination Depression Mood Swings

Stress Poor Memory Anxiety Irritability

Disorientation Migraines Easily Angered Headache

Have you ever received psychiatric treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever considered or attempted suicide? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any nervous habits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other problems you would like us to be aware of ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Musculo-Skeletal**

Neck Pain Back Pain Joint Pain Muscle Spasms Hand/Wrist Pain

Scoliosis Shoulder Pain Knee Pain Muscle Cramping

Hip Pain Arthritis Muscle Weakness Muscle Soreness

Recent Sprains Weak Joints Injuries Foot/Ankle Pain

**Please Circle Any Areas of Pain or Injury**

**Please be prepared to describe the type and quality of pain**



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# Consent for Treatment

I, the undersigned, consent to treatment at *The Acupuncture Center*. I understand that treatment may include the use of acupuncture needles, electrical acupuncture, cupping, Chinese herb medicine (raw, granules and patent forms, etc.), acupressure, Chinese massage (Tui Na), Chinese food therapy, spinal manipulation and Chinese fitness and nutritional counseling.

I fully understand the risks of treatment, although very limited, could include the following: slight burns from a mineral heat lamp, slight bruising from cupping and needles, herbal side effects, or allergic reactions. (Some herbs and certain acupuncture points should not be used with pregnant females.) If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs or pharmaceuticals, am pregnant or suspect that I might be pregnant, I agree that I will inform the practitioner before beginning treatment.

I accept that *The Acupuncture Center* cannot be held liable for any intentional misrepresentations by myself. I state that I have read the “*Consent for Treatment*” form in its entirety and understand and accept the risks involved in treatment.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following is if patient under 18;

Responsible Party’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Gender: M/F Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Telephone: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_