Bohemia Healing Spa

Acupuncture Intake Form

All Information is Strictly Confidential

Name____ Date of Birth____________________

Address____City/State/Zip____________________

Phone:(H)__________________ (W)______________________ (C)______________________

Email ________________________________Occupation________________________________

Whom may we thank for your referral? ____

Please take a moment to answer the following questions:

Have you had acupuncture treatments before? ❑Yes ❑No *When?* ____________________

What are your particular goals for this acupuncture session?

____

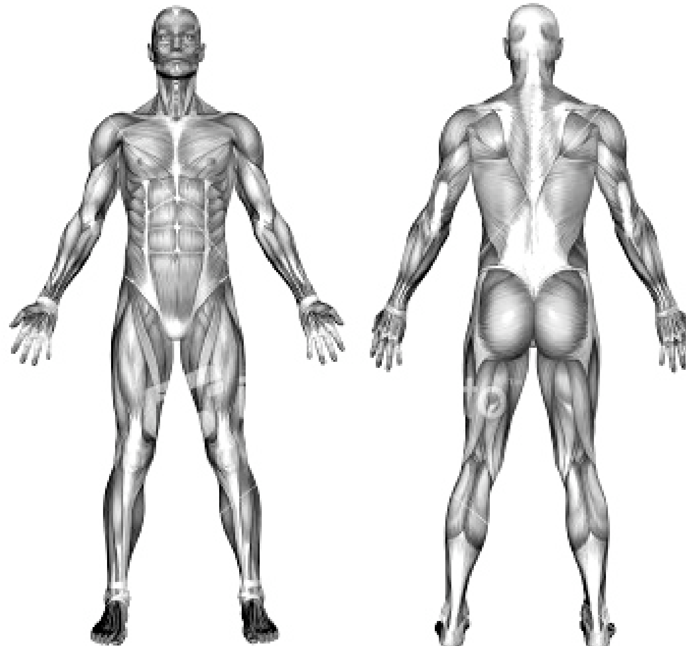
Do you frequently feel stressed? ❑Yes ❑No

How would you describe your current state of health? ______________________________

When do you last remember feeling really great? ____________________________________

Are you currently pregnant or breastfeeding? ❑Yes ❑No

Please mark on the figures below where you are experiencing any discomfort, pain, or tension.



609 West Douglas ✂ Wichita, Kansas 67213 ✂ tel: 316.262.7888

www.bohemiahealingspa.com

Are you currently under the care of any of the following medical professionals?

- ❑ Medical Doctor
- ❑ Chiropractor
- ❑ Acupuncturist
- ❑ Physical Therapist
- ❑ Naturopath
- ❑ Massage Therapist
- ❑ Nutritionist
- ❑ Psychiatrist
- ❑ Personal Trainer

Please check any that apply:

Musculoskeletal System
- ❑ Arthritis
- ❑ Artificial Joint
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Joint Pain
- ❑ Muscular Dystrophy
- ❑ Osteoporosis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Whiplash

Respiratory System
- ❑ Asthma
- ❑ Allergies
- ❑ Bronchitis
- ❑ Sinusitis
- ❑ Frequent Cold/ Flu

Circulatory System
- ❑ Atherosclerosis
- ❑ Thrombosis
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Stroke
- ❑ Varicose Veins
- ❑ Poor Circulation

Digestive System
- ❑ Recent change in appetite
- ❑ Acid Reflux
- ❑ Diarrhea
- ❑ Constipation
- ❑ Ulcers
- ❑ Food Allergies
- ❑ Gall Stones
- ❑ Hepatitis

Immune System
- ❑ Cancer
- ❑ Chronic Fatigue Syndrome
- ❑ Fibromyalgia
- ❑ Diabetes
- ❑ Edema
- ❑ HIV/AIDS
- ❑ Lupus
- ❑ Lymphoma

Nervous System
- ❑ Alzheimer's
- ❑ Headaches or Migraines
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Seizures
- ❑ Sleep Disorders
- ❑ Shingles
- ❑ Spinal Cord Injury

Integumentary System (Skin)
- ❑ Burns
- ❑ Dermatitis
- ❑ Eczema
- ❑ Fungal Infections
- ❑ Impetigo
- ❑ Scars
- ❑ Rash

Emotional System
- ❑ Depression
- ❑ Anxiety
- ❑ Grief
- ❑ Anger
- ❑ Joy

Female Reproductive System
- ❑ Irregular Menstruation
- ❑ Painful Menstruation
- ❑ Difficult Conception
- ❑ Miscarriage
- ❑ Endometriosis
- ❑ Menopause
- ❑ Hysterectomy

Urinary System
- ❑ Frequent Urination
- ❑ UTI
- ❑ Kidney Stones

Additional Health Concerns: ____

____

____

What seems to make you feel better? ______________________________________

What seems to make you feel worse? ______________________________________

Have you had any accidents, illnesses, injuries, surgeries, or traumas that have affected your health in such a manner that you've never been totally well since? ❑Yes ❑No
Please list with approximate date

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____

____

Please list any medications, with dosages, that you are currently taking:

____

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____

____

Please list any vitamins, minerals, and herbs, with dosages, that you are currently taking:

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____

Please read the following statements, initial, and sign below in agreement and for consent to treatment:

_____ There is currently no regulatory board regarding acupuncture or oriental medicine in the state of Kansas. Kali Day and Bohemia Healing Spa abide by the highest standards of safety for your ultimate wellbeing. I understand that every precaution shall be made in my best interest and that all information that I share in the treatment setting shall be confidential.

_____ In the event you are unable to make an appointment, 24 hours notice is respectfully requested, so that we can offer your appointment time to someone else and reschedule your appointment for a new time that is better for you. Late cancellations and missed appointments will be billed at full price.

_____ To allow all patrons and practitioners of Bohemia Healing Spa the greatest sense of serenity, please turn off your cellular phone, or in the case of urgency, turn it to a non-audible mode.

_____ I hereby authorize Kali Day to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following: (1) the insertion of various styles of sterile, one-time use acupuncture needles into my body at various depths and locations; (2) massage of the acupoints or channels; (3) moxabustion, a heat treatment using the herb arthemesa vulgaris; (4) Acutonics, a form of sound wave therapy; (5) homecare suggestions such as dietary changes or supplements, exercises, lifestyle recommendations, or referral to other specialists.

______ I have been informed that I have a right to refuse any form of treatment. I understand the nature of the treatment and the risks and possible consequences involved with acupuncture. In each treatment session there are opportunities to ask questions pertaining to my treatment. I understand that there is always a possibility of unexpected complications and that no guarantee can be made concerning the results of the treatment.

All information is correct to the best of my knowledge and it is my responsibility to inform Kali Day and Bohemia Healing Spa of any changes during the course of my treatment.

____ ____ ____________

Signature of Patient (or Patient's Guardian) Date