

Confidential Case History

Vahila Acupuncture and Massage Therapy
4643 18th St. NW • Canton, OH 44708 • 330-477-0777
www.cantonacupuncture.com

Name _____ Today's Date _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work or cell phone _____
E mail _____
Date of Birth _____ Occupation _____
Referred by _____
Have you had acupuncture before? _____ Have you had massage therapy before? _____
In case of emergency contact _____ Phone _____

Reason for Visit

Present symptoms/Major concerns _____
How long have you had this condition? _____
What was the initial cause? _____
What seems to make it better? _____
What seems to make it worse? _____
Has there been a medical diagnosis? _____ When? _____
Name of the doctor who gave the diagnosis _____
Are you currently receiving treatment for this condition? Yes No
If yes, please describe your treatment _____

Medical History

Please list previous conditions for which you were treated _____

List any conditions for which you are currently being treated _____

Please list any medications you are taking _____

Please list any medical implants (pacemaker, joint replacements, etc.) _____

List previous surgeries _____

Describe any significant traumas (car accidents, falls, etc.) _____

List any allergies _____

(Note: we may use lubricants that contain peanut, soy or other nut, seed or vegetable oils, essential oils of plants such as lavender, pine, etc. or metal needles and pellets that contain silver, gold, other metals or silicon coating.)

Do you have, or have you ever had, any infectious disease? Yes No

(Note: These include HIV/Aids, Hepatitis B or C, TB etc.)

Please describe _____

Lifestyle

Do you take nutritional supplements? Yes No Please list them _____

Do you consume: coffee tea soft drinks

alcohol recreational drugs tobacco

Do you exercise? Yes No If so, please describe: _____

List major areas of stress in your life _____

Marital Status _____

General Symptoms

- | | | |
|---|---|--|
| <input type="checkbox"/> Fatigue/tiredness | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Crave sweets | <input type="checkbox"/> Bloating after meals |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Spontaneous sweating |
| <input type="checkbox"/> Weakness of voice | <input type="checkbox"/> Weak cough | <input type="checkbox"/> Phlegm |
| If there is phlegm, what color is it? | <input type="checkbox"/> Yellow, brown or green | <input type="checkbox"/> White |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Tightness in chest | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Weak or sore low back or knees | <input type="checkbox"/> Incontinence | |
| <input type="checkbox"/> Distention, fullness, pressure or oppression in any areas. Where _____ | | |
| <input type="checkbox"/> Nervous tension | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Symptoms worse with menstruation | | |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Numbness of extremities |
| <input type="checkbox"/> Dry or pale skin | <input type="checkbox"/> Dry, brittle or pale nails | |
| <input type="checkbox"/> Spider or varicose veins | <input type="checkbox"/> Fixed lumps in breast or abdomen | <input type="checkbox"/> Age spots |
| <input type="checkbox"/> Symptoms worse at night | <input type="checkbox"/> Purple lips or nails | <input type="checkbox"/> Menstrual clots |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Heat in the chest, palms of hands or soles of feet | |
| <input type="checkbox"/> Dry mouth or throat | <input type="checkbox"/> Red or flushed cheeks | <input type="checkbox"/> Darker yellow urine |
| <input type="checkbox"/> Aversion to cold | <input type="checkbox"/> Cold hands, feet or nose | <input type="checkbox"/> Clear, abundant urine |
| <input type="checkbox"/> Waking at night to urinate | <input type="checkbox"/> Decreased sexual desire | |
| <input type="checkbox"/> Increased or rapid hunger | <input type="checkbox"/> Mouth or tongue sores | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Constipation |

Where do you have pain (if any)? _____

What is the quality of the pain? Dull Pressure/distention Fixed/stabbing/sharp

Moves around from one area to another Heavy Burning

List any other symptoms or health concerns _____

Consent to Treatment

By signing below, I voluntarily consent to be treated with acupuncture and/or massage by Michael Vahila, National Board Certified Acupuncturist and Licensed Massage Therapist and/or Marcia Vahila, Licensed Massage Therapist. I understand that acupuncturists practicing in the state of Ohio are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this office.

Massage therapy: I understand that Massage therapy involves the manipulation of the body through manual techniques. I am aware that certain side effects may result. These include, but are not limited to: bruising, and the possible aggravation of symptoms.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on the body to treat dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that acupuncture is a generally safe method of treatment but it may have some side effects. These include, but are not limited to: bruising, numbness or tingling near needling sites, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that there are no guarantees concerning its use and that I am free to stop acupuncture treatment at any time. **Non-Needle Micro-current Therapy:** I understand that I may be asked to have Non-Needle Micro-current Therapy administered. While this is a very gentle and safe treatment, I am aware that certain side effects may result. These may include, but are not limited to: tingling sensations, discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may choose not to have this treatment.

Notice of Privacy Practices

Your personal health information (PHI) will be used to provide you with treatment and for payment information. It will be disclosed to others only if you have given a written consent, if there is a threat to you or others, or it is required by law. You have a right to inspect your PHI. You may request an amendment to your PHI if there is an error or if it is incomplete. I acknowledge that I have received a copy of the Informed Consent and Notice of Privacy Practices.

I affirm that all information provided on this intake form is correct and assume any and all responsibility for incorrect or withheld information. I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask questions about the benefits and risks of treatment. I give my permission and consent to treatment. This permission is to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

Patient Signature: _____ **Date:** _____

Informed Consent/Notice of Privacy Practices - Patient Copy
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