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

❑ Fatigue/tiredness ❑ Lack of strength ❑ Easy bruising

❑ Poor appetite ❑ Crave sweets ❑ Bloating after meals

❑ Loose stools ❑ Shortness of breath ❑ Spontaneous sweating

❑ Weakness of voice ❑ Weak cough ❑ Phlegm

If there is phlegm, what color is it? ❑ Yellow, brown or green ❑ White

❑ Heart palpitations ❑ Tightness in chest ❑ Poor memory

❑ Weak or sore low back or knees ❑ Incontinence

❑ Distention, fullness, pressure or oppression in any areas. Where_____

❑ Nervous tension ❑ Irritability ❑ Depression

❑ Symptoms worse with menstruation

❑ Blurred vision ❑ Night blindness ❑ Numbness of extremities

❑ Dry or pale skin ❑ Dry, brittle or pale nails

❑ Spider or varicose veins ❑ Fixed lumps in breast or abdomen ❑ Age spots

❑ Symptoms worse at night ❑ Purple lips or nails ❑ Menstrual clots

❑ Night sweats ❑ Heat in the chest, palms of hands or soles of feet

❑ Dry mouth or throat ❑ Red or flushed cheeks ❑ Darker yellow urine

❑ Aversion to cold ❑ Cold hands, feet or nose ❑ Clear, abundant urine

❑ Waking at night to urinate ❑ Decreased sexual desire

❑ Increased or rapid hunger ❑ Mouth or tongue sores ❑ Bleeding gums

❑ Insomnia ❑ Dizziness ❑ 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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