



# MAMA LOUNGE

2001 PINE STREET SAN FRANCISCO, CA 94115 (415) 857-3228 MAMALOUNGESF.COM

## **New Patient Intake**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone(cell) \_\_\_\_\_

E-mail address: \_\_\_\_\_

How did you hear about Mama Lounge? Friend - (who?) \_\_\_\_\_

Internet \_\_\_\_\_ MD/Midwife \_\_\_\_\_ Other \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Regular Medical Doctor: \_\_\_\_\_

Other Specialist / PT / Chiro / ND: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### **Chief Complaint (Please identify your major health concerns):**

1. \_\_\_\_\_ Since Age: \_\_\_\_\_

2. \_\_\_\_\_ Since Age: \_\_\_\_\_

3. \_\_\_\_\_ Since Age: \_\_\_\_\_

### **General Questions**

Have you ever had acupuncture before? Y N

Are you now or could you be pregnant? Y N

Date of conception \_\_\_\_\_

Do you have a history of miscarriage? Y N

Do you have a pacemaker, heart arrhythmia, or other heart condition? Y N

Have you ever had blood-clotting problems or problems with bleeding? Y N

Are you on blood thinning medications? Y N

Do you take aspirin regularly? Y N

Have you ever been diagnosed with Hepatitis? HIV? AIDS? TB? Y N When? \_\_\_\_\_

Surgical History: Please list all surgeries and approximate age:

---

---

Hospitalizations and approximate date:

---

---

Specific allergies and reaction:

---

---

Major Accidents/Injuries (include head injuries, fractures, deep cuts, serious sprains, etc.) Indicate date or age:

---

---

Were there any abnormal or memorable conditions surrounding your birth:

---

---

**Family Medical History (any medical conditions that run in your family):**

Diabetes Who \_\_\_\_\_

Cancer Who \_\_\_\_\_

High Blood Pressure Who \_\_\_\_\_

Heart Disease Who \_\_\_\_\_

Stroke Depression/Mental Illness Who \_\_\_\_\_

Alcoholism/Drugs Who \_\_\_\_\_

Other \_\_\_\_\_ Who \_\_\_\_\_

**Medication History**

Have you taken oral contraceptives? Yes No When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you taken medication to help you ovulate? Yes No When? \_\_\_\_\_ How long? \_\_\_\_\_

List all **medications and supplements** you are currently taking:

RX: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

RX: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

RX: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

RX: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

RX: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_

**Emotions & Sleep:**

Do you have (circle all that apply): panic/anxiety attacks bad/short temper nervousness sadness crying spells tendency to worry poor memory difficult concentration

Briefly describe a typical night of sleep for you. \_\_\_\_\_

How long do you normally sleep? \_\_\_\_\_ hours per night Do you take naps? \_\_\_\_\_ How often? \_\_\_\_\_

I have difficulties with (circle all that apply): falling asleep staying asleep dream-disturbed sleep

Do you often experience waking up and not being able to fall asleep again?  No  Yes, usually at \_\_\_\_\_ am/pm

Number of times per night you get up to use the restroom \_\_\_\_\_

On a scale of 1-10 please rate your stress level \_\_\_\_\_

How do you relax? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

Are you in a relationship? \_\_\_\_\_ How do you feel about your relationship? \_\_\_\_\_

What is your most predominant emotion? \_\_\_\_\_

**Please check the box next to any conditions that apply to you, past and/or present**

**Head and Face**

- Headaches
- Dizziness
- Memory Loss

**Eyes**

- Blurry Vision
- Eyelid Twitching
- Floaters
- Pain

**Nose**

- Tremors
- Frequent Colds
- Sinus Trouble
- Bleeding

**Mouth**

- Dental Problems
- Gum Problems
- Teeth Grinding/TMJ
- Unusual Tastes
- Other

**Throat**

- Sore Throat
- Hoarseness
- Difficulty Swallowing
- Dryness
- Other

**Heart and Chest**

- High Blood Pressure
- Low Blood Pressure
- Chest Pain
- Chest Tightness
- Difficulty Lying Down
- Other

**Circulation**

- Easy Bruising
- Easy Bleeding
- Cold Limbs-Hands or Feet
- Body Temp Runs Cold
- Body Temp Runs Hot

**Gastrointestinal**

- Always Thirsty
- Never Thirsty
- Excessive Appetite
- Low Appetite
- Gas/Bloating
- Stomach or Abdominal Pain
- Nausea
- Diarrhea/Loose Stools
- Constipation
- Rectal Bleeding
- Colon Problems

**Urination**

- Frequent
- Difficult

**Skin**

- Acne
- Dryness
- Moles that Change
- Lumps
- Excessive Sweating
- Night Sweats
- Rarely Sweat
- Other

**Neurological**

- Nervousness/Anxiety
- Numbness or Tingling
- Lack of Coordination
- Nerve Pain

**Well-Woman History**

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

Have you ever had a venereal disease? Yes No What kind? \_\_\_\_\_

Do you get yeast infections regularly? Yes No

Do you have chronic vaginal discharge? Yes No

Do you douche regularly? Yes No With what? \_\_\_\_\_

Do you use vaginal lubricants? Yes No Which Ones? \_\_\_\_\_

Do you use tampons? Yes No Do you sleep with one in? Yes No

Do you ever experience pain with sex? Yes No

Age at which menses began \_\_\_\_\_ menses stopped \_\_\_\_\_

Are your periods painful? Yes No

How many days do you normally bleed? \_\_\_\_\_

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown Black

Is there clotting? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender when you are premenstrual? Yes No

Do you get premenstrual low back pain? Yes No

Do you bleed or spot between periods? Yes No

How many days are there from one period to the next? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Have your cycles changed since they began? Yes No

Do you ovulate on your own? Yes No On what day of your cycle? \_\_\_\_\_

Do your breasts become tender at ovulation? Yes No

Do you experience pain at ovulation? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever had pelvic inflammatory disease? Yes No Were you treated for it? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic abnormalities? Yes No

Have you had surgeries besides a D&C? Yes No When? \_\_\_\_\_ What kind? \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Were there complications during your pregnancies? Yes No If yes, what? \_\_\_\_\_

How many abortions have you had? \_\_\_\_\_

How many miscarriages have you had? \_\_\_\_\_

How many times has a D & C been performed? \_\_\_\_\_

## **Patient Informed Consent to Care and Treatment**

### **Acupuncture Consent to Treat**

1. I, \_\_\_\_\_, hereby authorize the licensed acupuncturist at Mama Lounge to administer any style of Chinese Medicine relevant to my diagnosis and treatment, including but not limited to the following:

- Insertion of disposable, stainless steel acupuncture needles of various sizes into my body at different depths and locations.
- Heated moxibustion treatment using the herb Artemisia Vulgaris, or a heat lamp may be placed on or near any part of my body. There is also indirect moxibustion treatment where the herb may rest on the skin. The heat might cause slight discomfort or leave a small scar or blister on the skin. With any type of heat, there is risk of burn.!
- Vigorous massage called "gua sha" or regular massage that may produce redness, tenderness or slight bruising of the skin,
- Cupping may be used to promote circulation. Suction from the cups may produce red or purple bruising.
- Electrical Stimulation may be used to enhance the treatment at various acupuncture points.

2. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases, dizziness or fainting. Although rare, there have been reports of nerve damage and organ puncture connected to acupuncture treatment. Infection is also a possible risk. However, I understand that this office uses only sterile disposable single-use needles, and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

3. The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify the licensed acupuncturist at Mama Lounge if I am or become pregnant. I will notify the licensed acupuncturist at Mama Lounge immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements. I do not expect the licensed acupuncturist at Mama Lounge to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

4. I understand the licensed acupuncturist at Mama Lounge has the right to refuse treatment to any patient at any time. Reasons for refusal of treatment include crude behavior or inappropriate conduct

### **Massage Consent to Treat**

1. I give my permission to receive massage therapy at Mama Lounge

2. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.

3. I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.

4. I have clearance from my physician to receive massage therapy.

5. I understand the risks associated with massage therapy include, but are not limited to: superficial bruising, short-term muscle soreness, exacerbation of undiscovered injury; I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

6. I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.

7. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so she may adjust accordingly.

8. I understand that I or the massage therapist may terminate the session at any time.

9. I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

**Counseling Consent to Treat**

**1. Confidentiality**

All information obtained in the course of the professional service is confidential unless there is a compelling professional reason for its disclosure. Your coach will disclose confidential information without a specific release if it is necessary to prevent foreseeable imminent harm to the client or another. In all circumstances, the coach will be judicious in the amount of information that is disclosed.

Coaches may disclose confidential information without the consent of the client only as mandated or permitted by law. When possible, coaches inform clients about the disclosure of confidential information and possible ramifications before the disclosure is made. Coaches will only disclose confidential information to third parties with the appropriate written consent.

**2. Liability**

This agreement is for Coaching, not Psychotherapy. Ms. Carol Jones is working only within the capacities of a Coach and will not be held liable for discrepancies. While coaching can work with issues such as identifying and reaching goals, and changing the behaviors that aren't working well for you, coaching will not address psychological issues such as depression and anxiety. For issues such as these, seek the medical attention from a Physician or Licensed Mental Health Professional in your area. By signing this agreement, you are agreeing that you understand the difference in these two functions and you will get appropriate professional help for mental health issues if necessary.

**Authorization to Release or Obtain Information**

I hereby authorize my provider at Mama Lounge to exchange all pertinent clinical information pertaining to me with other providers in the practice. I hereby release from liability and agree to indemnify and hold forever harmless all persons involved in this exchange of information from any loss, damage, claim or legal action arising out of such exchange of information. I understand these records may include personal and psychological information, and I may withdraw this authorization at any time, except to the extent that action has been taken on this authorization.

By voluntarily signing below, I show that I have read (or have had read to me) and understand this consent to treatment. I have been told about the risks and benefits of acupuncture/massage/counseling and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

**Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_