OLY FLOAT

1. Please enter your information.

First Name: | Middle Initials: | Last Name: | Date of Birth:

Gender:
○ Female ○ Male

Social Security #:

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Mobile Phone: | Home Phone: | Work Phone:

Email:

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

May we leave a message?
○ Yes ○ No

Employer:

Preferred Language:
○ English ○ Spanish ○ Other:

If other, please specify:

Race (Please check all that apply):
☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander ☐ Other:

If other, please specify:

Ethnicity:
☐ Hispanic/Latino(a)

How did you learn about this office?

Who referred you?

2. Emergency Contact Information.

Emergency Contact Name: | Relationship:

Address: | Apt/Unit #:

Phone Number: | Alt Phone Number:

What brings you in today?

3. Problem 1

Please detail the first problem:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Anything make it better?

Anything make it worse?

Is this problem affecting your daily life, work or sleep?
○ Yes ○ No

If yes, please explain:

Have you been treated for this problem before?
○ Yes ○ No

If yes, please explain:

4. Problem 2

Please detail the second problem:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Anything make it better?

Anything make it worse?

Is this problem affecting your daily life, work or sleep?
○ Yes ○ No

If yes, please explain:

Have you been treated for this problem before?
○ Yes ○ No

If yes, please explain:

5. Have you had any recent stressful events or significant life changes? (i.e. recent death, divorce, job loss)

6. Have you had acupuncture before?
○ Yes ○ No

Any fear of needles?
○ Yes ○ No

What are your goals with this acupuncture session?

SYMPTOMS

7. Indicate if you have any of the following symptoms:

- ☐ Fatigue
- ☐ Slow Wound Healing
- ☐ Ringing in the Ears
- ☐ Sore Throat
- ☐ Confusion
- ☐ Headaches
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Excessive Thirst
- ☐ Cold Extremities
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Ankle Swelling
- ☐ Urine Urgency
- ☐ Skin Rashes/Hives
- ☐ Numbness/Tingling
- ☐ Food Cravings
- ☐ Anxiety
- ☐ Irritability/Anger
- ☐ Substance Abuse
- ☐ Unexplained weight loss or gain
- ☐ Vision Problems
- ☐ Congestion
- ☐ Ear Pain
- ☐ Difficulty Making Decisions
- ☐ Blood Clots
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Dry Hair/Skin
- ☐ Frequent Colds
- ☐ Snoring
- ☐ Heart Palpitations
- ☐ Painful Urination
- ☐ Infertility
- ☐ Joint/ Muscle Pain
- ☐ Swollen Glands
- ☐ Recent Antibiotic Use
- ☐ Mood Swings
- ☐ Lack of Pleasure
- ☐ Night sweats
- ☐ Red/Dry/Itchy eyes
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Dizzy/Lightheaded
- ☐ Easy Bruising/Bleeding
- ☐ Constipation
- ☐ Food Sensitivities
- ☐ Change in Appetite
- ☐ Heat or Cold Intolerance
- ☐ Post nasal drip
- ☐ Wheeze/Cough
- ☐ Leg Pain with Walking
- ☐ Nighttime Urination
- ☐ Impotence
- ☐ Joint Swelling
- ☐ Seasonal Allergies
- ☐ Depressed Mood
- ☐ Heavy Body Sensation
- ☐ Poor Sleep

MEDICAL AND HEALTH HISTORY

8.

	Excellent	Good	Fair	Poor
How would you rate your physical health?				
How would you rate your emotional health?				
How would you rate your spiritual life?				
How would you rate your family life?				
How would you rate your quality of life?				

9. List any other medical or psychiatric diagnoses you have:

_____

_____

_____

_____

10. Past surgeries?

○ Yes ○ No

11. If yes, please list:

	Surgery	Year(s)	Notes/Comments
1			
2			
3			

MEDICATIONS

12. List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Name	Dose	Frequency	Reason for Taking?
1				
2				
3				

13. Do you take blood thinning medication?
○ Yes ○ No

Any Allergies?
○ Yes ○ No

14. Please list any allergies:

	Allergic to?	Reaction
1		
2		
3		

DIET

15. Describe your average daily diet:

Morning:

Afternoon:

Evening:

List any dietary restrictions:

Food cravings:

FEMALES

MEN

FAMILY HISTORY

16. Does anyone in your family have a history of:

	Yes	No	Who?
Allergies	Yes	No	
Cancer	Yes	No	
Depression	Yes	No	
Diabetes	Yes	No	
Emotional Problems	Yes	No	
High Blood Pressure	Yes	No	

Heart Problems	Yes	No	
Immune Disorder	Yes	No	
Kidney Disorder	Yes	No	
Thyroid Disorder	Yes	No	
Other: (specify what)	Yes	No	

OLY FLOAT

Acupuncture Waiver

Symone Milev holds the following qualifications in the practice of acupuncture:

1. Master's Degree of Acupuncture and Chinese Medicine

2. Certificate of Herbal Medicine from the Academy of Five Elements in Gainesville, Florida

3. Washington state license to practice acupuncture (AC61560558)

Acupuncture treatment at Oly Float is based upon standardized treatments that have been shown through evidence-informed practice to implement certain health benefits.

It is important to note that the acupuncture procedure has very minor risks associated with it, which include (in decreasing order of prevalence):

- Nominal bleeding

- Very slight insertion sight soreness

- Minimal bruising

Further, under the guidance of a highly trained and licensed professional, all other physical risks are essentially non-existent.

It is important to note that post-treatment, the majority of clients experience extreme relaxation. Occasionally, this feeling of relaxation can be combined with mild disorientation, decreased blood pressure, dizziness, and fatigue. Please ensure that you listen to your body's needs after treatment, including but not limited to taking your time getting up and remaining on site until you feel comfortable to travel home.

By signing below, I acknowledge that I have read the aforementioned information, understand it in its entirety, and wholly consent to receive acupuncture treatment

_____ _____

Client Signature Date