Acupuncture Intake Form

Name: ______________________ Phone: ____________ DOB: ________ SS#: ____________

Marital Status: ____________ Height: _____ Weight: _____ Email: ____________ Occupation: ____________

Address: ______________________ City/State/Zip: ____________________ Referral: ____________

Emergency Contact:

Name: ______________________ Phone: ____________________ Relationship: ____________

The Basics:

Please check any of the following that are a part of your lifestyle:

- ☐ Alcohol
- ☐ Drugs
- ☐ Tobacco
- ☐ Stress
- ☐ Marijuana
- ☐ Occupational Hazards
- ☐ Regular Exercise
  - Type: ____________________ Frequency: ____________
  - Type: ____________________ Frequency: ____________

Please check any of the following that are a part of your diet:

- ☐ Coffee/ Tea
- ☐ Salty foods
- ☐ Soft Drinks
- ☐ Artificial Sweeteners
- ☐ Fruit Juices
- ☐ Sugar

Appetite: ☐ Low ☐ Average ☐ High

Protein Intake: ☐ Low ☐ Average ☐ High

Glasses of water per day: _____

Please describe what your average daily menu looks like (Breakfast, Lunch, Dinner, and any Snacks)

Have you had acupuncture before? ☐ Yes ☐ No

Chinese herbal medicine? ☐ Yes ☐ No

Reason for your visit today: ______________________________

Is it getting worse? ☐ Yes ☐ No

What seems to make it worse? ______________________________

Does it bother you when your: ☐ Sleep ☐ Work ☐ Other Specify: ______________________________

What seemed to be the initial cause? ______________________________

Please check any of the following that are applicable to your general symptoms:

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Strongly like cold drinks
- ☐ Strongly like hot drinks
- ☐ Recent weight gain/loss
- ☐ Poor Sleep
- ☐ Heavy Sleep
- ☐ Dream-disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Bleed or bruise easily
- ☐ Muscle cramps
- ☐ Vertigo/ Dizziness
- ☐ Bodily heaviness
- ☐ Cold hands or feet (poor circulation)
- ☐ Shortness of breath
- ☐ Chills
- ☐ Fever

Medical:

Are you under the care of a physician now? ☐ Yes ☐ No If yes, for what? ____________

Physician's name: ______________________ Physician's phone: ____________

Other Concurrent Therapies: ______________________________

Health Insurance Info:

Insurance Co. Name: ______________________ Policy #: ____________

Address: ____________ City: ________ State: _____ Zip: ________ Phone: ____________

Medicare Info:

Insurance Co. Name: ______________________ Policy#: ____________

Address: ____________ City: ________ State: _____ Zip: ________ Phone: ____________

Pharmaceuticals taken in the last 2 months: ______________________________

Vitamins/ Supplements taken in the last 2 months: ______________________________

Your Past Medical History: **Please mark any of the following you **have or have experienced.**

- AIDS/HIV
- Alcoholism
- Allergies
- Appendicitis
- Arteriosclerosis
- Asthma
- Birth Trauma (your own birth)
- Cancer
- Chicken Pox
- Diabetes (Types: ___________)
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart Disease
- Hepatitis (Type: ________)
- Herpes (Type: ________)
- High Blood Pressure
- Measles
- Multiple Sclerosis
- Mumps
- Pacemaker (Date: ______)
- Pleurisy
- Pneumonia
- Polio
- Rheumatic Fever
- Scarlet Fever
- Seizures
- Stroke
- Thyroid Disorders
- Tuberculosis
- Typhoid fever
- Ulcers
- Venereal disease
- Whooping cough
- Others, please specify:

List any surgeries you have had (if not applicable please write“NA”)

List any major traumas you have had-car accidents, falls, etc.- (if not applicable please write“NA)

Family Medical History: Please check all that apply:

- Allergies:
- Arteriosclerosis
- Asthma
- Alcoholism
- Cancer:
- Depression
- Heart Disease
- Seizures
- Stroke

Gynecology:

Age menses began: ________________________________ Date of last PAP: ________________________________

Length of cycle: ________________________________ Date last period began: ________________________________

Please mark any of the following you **have or have experienced.

- Irregular periods
- Breast lumps
- Vaginal sores
- Clots
- Vaginal odor
- Vaginal discharge (Color:____)

Pregnancies ______
Live births ______
Premature ______
Age at menopause ______

Please list any other symptoms you are experiencing below:

Additional Symptoms: **Please mark any of the following you **have or have experienced.**

- Eye strain
- Glasses (What age:____)
- Eye pain
- Red eyes
- Itchy Eyes
- Spots in eyes
- Poor vision
- Blurred vision
- Night blindness
- Myopia or Presbyopia
- Glaucoma
- Cataracts
- Teeth Problems
- Grinding Teeth
- TMJ
- Facial pain
- Gum Problems
- Sores on lips or tongue
- Dry Mouth
- Excessive saliva
- Sinus problems
- Excessive phlegm (Color:______)
- Recurent sore throat
- Swollen glands
- Lumps in throat
- Enlarged thyroid
- Nosebleeds
- Ringing in ears (High or Low)
- Poor hearing
- Earaches
- Headaches
- Migraines
- Concussions
- Difficulty breathing when laying down
- Tight chest
- Difficult Inhalation or Exhalation
- Cough
- Coughing up blood
- Blood Clots
- Fainting
- Chest pain
- Tachycardia
- Irregular Heartbeat
- Nausea
- Vomiting
- Acid Regurgitaion
- Gas
- Hiccups
- Bloating
- Bad breath
- Diarrhea
- Constipation - Laxative use? ______
  Kind_____ Frequency________
- Black stools
- Rectal pain
- Bloody Stools
- Anal fissures
- Mucus in stools
- Hemorrhoid
- Itchy anus
- Intestinal pain or cramping
- Burning anus
- Neck/ shoulder pain
- Muscle pain
- Back pain ☐ Upper ☐ Lower
- Joint pain
- Rib pain
- Limited range of motion
- Hives
- Rashes
- Ulceration
- Psoriasis
- Acne
- Dandruff
- Eczema
- Itching
- Hair loss
- Change in hair/skin texture
- Fungal infections
- Numbness
- Tics
- Poor memory
- Anxiety
- Irritability
- Abuse survivor
- Considered/ attempted suicide
- Seeing a therapist
- Pain on urination
- Frequent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Venereal disease
- Bedwetting
- Kidney Stones
- Increased/ decreased libido
- Impotence
- Premature ejaculation
- Nocturnal emission

Acupuncture and Oriental Medicine Informed Consent

I hereby request and consent to an interview and physical assessment according to the principles of Oriental medicine. I request and consent to have acupuncture and related physical modalities performed on me (or on the patient named below, for whom I am legally responsible) by the Licensed Acupuncturist named below and/or other Licensed Acupuncturists who work at this office. Every effort will be made to make the treatment comfortable.

Occasionally acupuncture and related physical modalities such as cupping, gua sha, moxibustion, etc. may result in momentary stinging, dizziness or fainting, bleeding, bruising, burns or blistering, pneumothorax, or others. I expect my acupuncturist to provide a general explanation of expected risks and benefits before the procedure and to exercise good judgment in my best interest given the facts known to him/her at the time.

I have discussed all of my medications or physical conditions with my acupuncturist (including blood pressure, diabetes, or blood thinning medications; pregnancy, pacemaker, or self or family history of seizure disorder) so that my treatment can be planned accordingly. I know of no physical condition that would prevent me from receiving acupuncture and Oriental medicine services.

In addition, the New York State Office of the Professions requires that patients read and sign the following statement before receiving treatment from a Licensed Acupuncturist.

WE THE UNDERSIGNED, DO AFFIRM THAT ______________________________ (THE PATIENT) HAS BEEN ADVISED BY ____ (THE ACUPUNCTURIST), TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Also, by signing below, I agree to The Center's Cancellation Policy that if I am unable to keep a scheduled appointment I will give The Center 24 hours' notice of cancellation. Otherwise, a cancellation fee of $50.00 will be billed to me.

______________________________ ______________________________

Patient Signature **Date**

______________________________ ______________________________

Parent/Guardian Signature **Date**

______________________________ ______________________________

Acupuncturist Signature **Date**

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receiving a copy of Notice of Privacy Practices, dated

______________________________ ______________________________

Patient's Name **DOB**

______________________________ ______________________________

Patient's Signature or Representative **Date**

*If signed by a Representative, the following information must also be included

______________________________ ______________________________

Name of Representative **Relationship to Patient**