

New Patient Intake

Patient Name _____ Date _____

General Information

Address		City	State
Home Phone		Occupation	Zip
Work Phone	Mobile Phone	SS#	Date of Birth
Email Address			
We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:		E-mails	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Texts	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Mail	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact		Relationship	Phone
Have you had Acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Family Physician	Phone
What was your experience? <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> No change		<input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single	
Are you presently under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No Who and what for? _____			
Are there any other therapies which you are involved in? <input type="checkbox"/> Yes <input type="checkbox"/> No Who and what for? _____			

Insurance Information

Insurance Company	Phone	Date Called
ID #	Co-Pay \$	Covered %
Visit #	Deductible Amount	
Contact Name	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	

Focus

What is the primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities? Work Standing Sexually Other
 Sleep Emotional Recreation
 Walking Relationships Bending
 Sitting Social Life Stretching

What have you done about this?

Are you interested in:
 Pain Relief Holistic Health Stress Relief Other
 Preventative Care Stretching/Yoga Herbal Therapy
 Oriental Nutrition Maintenance Care

What are your health goals?

List any past or future surgeries:

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.):

List exercise and sport activities you have been or are currently involved in:

Medical History

Do you have any allergies? Yes No If so, to what?

Do you take medication? Yes No If so, what types and how often?

Do you take supplements? Yes No If so, what types and how often?

Please indicate if you or any family members have or had any of the following conditions:

- | | | | | |
|---------------------------------------|--|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Drug reaction | <input type="checkbox"/> Mental breakdown | <input type="checkbox"/> Gonorrhea/Herpes | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Jaundice | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hypo/hyper thyroid |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Parasites | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Premature graying |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Obesity | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Cancer | |

Do you sleep well? Yes No

Do you dream? Yes No

Do you have a high point during the day? Yes No When? Do you have a low point during the day? Yes No When?

What are your indulgences?

What are your hobbies/pleasures?

Female Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No

Birth control? Yes No How long?

PMS Clotting Vaginal sores Vaginal pain Discharge

Other _____

Male Concerns

Testicle pain Penis pain Penis sores Discharge Premature ejaculation Nocturnal emission Impotence

Other _____

Chinese Organ Diagnostic Chart

Please rate symptom severity 1 to 5 (5 being worst). Leave blank if N/A

Liver/Gall Bladder

- ___ Irritability/ frustration/ impatient
- ___ Depression
- ___ Stress
- ___ Emotional Eating
- ___ Unfulfilled desires
- ___ Visual Problems/ floaters
- ___ Blurred vision/ poor night vision
- ___ Red/ Dry/ Itchy eyes
- ___ Headaches/ Migraines
- ___ Dizziness
- ___ Feeling of lump in throat
- ___ Muscle twitching/ spasm
- ___ Neck/ Shoulder tension
- ___ Brittle nails
- ___ Sighing
- ___ Sensation or pain under rib cage
- ___ PMS
- ___ Genital itching/ pain/ rashes

Heart/ Small Intestine

- ___ Palpitations
- ___ Chest pain/ tightness
- ___ Insomnia/ Sleep problems
- ___ Restless/ easily agitated
- ___ Vivid dreams
- ___ Lack of joy in life
- ___ Forgetful
- ___ Aversion to heat
- ___ Bitter taste in mouth
- ___ Tongue/ mouth ulcers/ cankers

Kidney/ Bladder

- ___ Frequent Urination
- ___ Bladder Infection
- ___ Lack of bladder control
- ___ Wake to urinate
- ___ Feel cold easily
- ___ Cold hands/ feet
- ___ Night sweats/ hot flushing
- ___ Low sex drive
- ___ High sex drive
- ___ Loss of head hair
- ___ Hearing problems
- ___ Crave salty foods
- ___ Fear
- ___ Poor long term memory
- ___ Ankle swelling
- ___ Tinnitus

Lung/ Large Intestine

- ___ Dry cough
- ___ Cough with Phlegm
- ___ Nasal discharge/ drip
- ___ Sinus infection/ congestion
- ___ Itchy/ painful throat
- ___ Dry mouth/ throat/ nose
- ___ Skin rashes/ hives
- ___ Snoring
- ___ Grief/ sadness
- ___ Shortness of breath
- ___ Allergies/ asthma
- ___ Weak immune system
- ___ Alternate fever/ chills

Spleen/ Stomach

- ___ Heaviness in the head/ body
- ___ Fatigue/ after eating
- ___ Difficult getting up in the morning
- ___ Water retention
- ___ Muscular tired/ weak
- ___ Bruise easily
- ___ Unusual bleeding (stool, nose, etc)
- ___ Bad breath
- ___ Poor appetite
- ___ Increased appetite
- ___ Crave sweets
- ___ Poor digestion
- ___ Nausea/ vomiting
- ___ Bloating/ Gas
- ___ Hemorrhoids
- ___ Constipation
- ___ Loose stool
- ___ Alternate constipation/ loose
- ___ Abdominal pain
- ___ Intestinal pain/ cramping
- ___ Heartburn
- ___ Pensive/ over-thinking
- ___ Overweight
- ___ Foggy mind
- ___ Yeast Infection
- ___ Aversion to cold
- ___ Cold nose
- ___ Increased Thirst
- ___ Prefer Warm/ Cold drinks
- ___ Sweat easily

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

No Pain Moderate pain Severe pain Terrible pain

Sleeping

No problem Disturbed Very disturbed Cannot sleep

Work - Can do:

Usual work 50% of work 25% of work No work

Frequency of pain

25% of time 50% of time 75% of time 100% of time

Travel

No problem Moderate pain on trips Severe pain

Recreation - Can do:

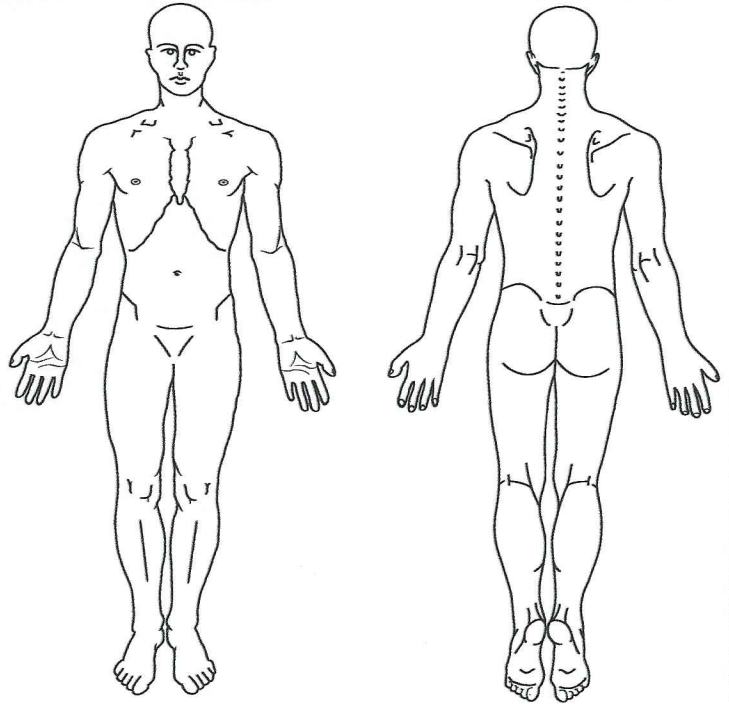
All activities Some activities No activities

Walking

Can walk fine Pain after 1/2 mile Cannot walk

Sitting

No pain sitting Some pain while sitting Cannot sit



Pain Key

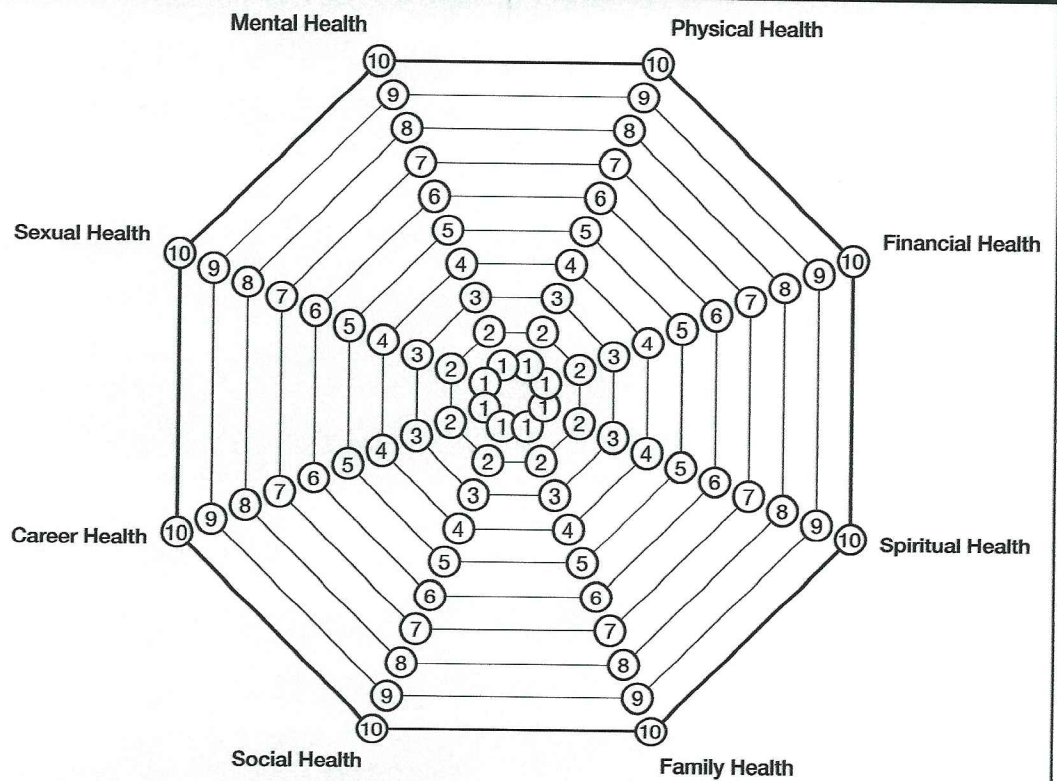
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	====	0 0 0 0	X X X X	///

Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____