Acupuncture /NRT Patient Intake Form

Date_____
Patient Name: _____Sex: M F DOB _____SSN _____

Address:_____City:_____State_____Zip_____ _____

Primary Phone:_____ Work Phone:_____

Cell Phone:_____
email:_____

Insurance provider_____ ID number_____
Primary Care Physician:_____ Referring Physician:_____

1. Please list the family members we may contact in the event of an emergency:

Name:_____ Phone:_____
Relationship:_____

Name:_____ Phone:_____
Relationship:_____

2. Can we leave messages regarding: (Please circle one)

Reminder calls: Home Cell Work All #'s

Confidential messages: Home Cell Work All #'s

I am aware of HIPAA privacy guidelines. I understand my rights regarding the protection of my personal health information (PHI). I understand that I have a right to revoke the above authorizations at any time. I hereby agree to pay for services in full.
I also understand that acupuncture treatments involve the use of sterile onetime use needles, moxibustion, acupressure tui-na, cupping, gua-sha and or electrical stimulation. The risks of acupuncture though quite limited include puncturing organs in the abdomen or chest cavities.
The duration of treatment varies from person to person depending on their specific state of disease or illness and constitution.
I understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.
Cancellation/No Show, a 24 hour notice is asked for all canceled appointments. If a 24hour notice is not provided or you do not show for an appointment you will be charged $90.00

Patient Signature:_____Date:_____

Parent or Guardian Signature:_____Date:_____ ____

Chief complaint _____

What caused this_____

How long_____ How often_____

What, if anything, makes your problem worse_____

What, if anything, makes your problem better _____

How does this affect your life_____

Other complaints

_____

Have you ever been treated by acupuncture or Oriental medicine before?_____

PAST MEDICAL HISTORY
Major or recurring illnesses_____

_____

Surgeries _____

_____

Significant trauma (auto accident, falls, etc.) _____

_____

Do you have or have you ever had any infectious diseases yes _____ no _____

If so, please describe_____

Medications/Supplements	Taken For:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies- please describe reaction
Foods_____
Medications_____
Environmental_____
Animals_____

FAMILY MEDICAL HISTORY (General Health)
Mother's side_____
Father's side_____
Siblings_____

Are there any other internal organ or systemic dysfunctions I should be aware of? _____

_____

SYMPTOMS: Please check your current symptoms.
Leave blank if not applicable.

HEAD/EYES/EARS/THROAT ____ spots in vision ____ TMJ
_____headaches

_____ migraines

_____ Foggy headed

_____ dizzy/vertigo

_____ memory loss

_____ concussions/head trauma

_____ eye strain/pain

_____ glasses/contact lens/reading

_____ red eyes/itchy/dry or watery

_____ night blindness

_____facial numbness

_____ nosebleeds

_____ nasal congestion

RESPIRATORY

_____ frequent colds/flu

_____ difficulty breathing/short of breath

_____chronic cough

_____ acute cough

_____ dry/ loose sputum / color_____

_____ tight chest

_____ asthma

CARDIOVASCULAR

_____chest pain

_____ rapid heart rate

_____palpitations

_____ pacemaker/ ICD

_____ irregular heart rate

_____ glaucoma

_____ cataracts

_____ hearing loss

_____ ear ringing/high pitch/low

_____ ear infections

_____ throat tickle/drainage

_____ sore throat

_____ swollen glands

_____ lump in throat

_____frequent urination

_____incomplete urination

_____ dribbling /incontinence

_____frequent urinary infections

_____blood in urine

____ bed wetting

_____pain with urination

_____ urinate _____x/ day

_____awaken to urinate _____x/night

_____increased libido

_____decreased libido

_____STD's type_____

MEN

_____ nocturnal emissions

_____ premature ejaculations

_____ impotence

WOMEN

_____pregnancies- term __ prem___

_____miscarriages

_____ abortions

_____ vaginal delivery/c section_____

_____age at menarche (first period)

_____ teeth grinding

_____teeth removed

_____ numerous cavities

_____ gum problems

_____ mouth sores

_____ excess saliva

_____ bad breath

_____ sinus problems

_____ facial pain

MUSCULOSKELETAL

_____acute pain

_____chronic pain

_____ muscle weakness

_____muscle cramps- location_____

_____muscle spasms

_____muscle atrophy

-_____joint pain

_____joint instability

_____joint implants_____locale

_____arhthritis- location_____

_____limited range of motion

_____ weather related pain

_____ general aches- location_____

NEUROPHYSIOLOGICAL

_____depression

_____ irritable

_____ easily stressed

_____easily frustrated

_____ anxious

_____grief

_____ numbness

____ hypertension
____ hypotension
____ fainting
_____edema/leg/feet/finger/body
____ enlarged heart
____ varicose veins
____ bruises easily/bleeding
____ poor circulation
____trouble falling asleep_
___ trouble staying asleep
____ awaken same time
____ vivid dreams

GI/GU
_____hiccups
____acid reflux
____ cravings- sweet/salty/sour____
_____bitter taste in mouth
____ indigestion/heartburn
____ abdominal pain
_____nausea/ vomiting
_____ gas/bloating
_____ frequency of BM____x/day/week___
_____light color stool
_____dark color stool_
____blood in stool
_____ mucus in stool
_____hemorrhoids
_____rectal pain/ itching_
____ color of urine_____
_____urine odor

____ age at menopause_
___ HRT use_
___perimenopausal
____PMS
____menses cycle length
____# days of bleeding
____pain with flow
____pain before flow
____spotting between cycles
_____blood clots
_____heavy bleeding
_____cycle absent or abnormal
_____vaginal odor
_____vaginal itching
_____vaginal dryness
_____vaginal pain
_____vaginal discharge
_____uterine fibroids
_____ovarian cysts
_____fibrocystic breasts
_____breast tenderness
_____breast lumps
_____bone density checked/changes
_____routine pap
_____routine mammogram/thermo

ENDOCRINE
_____hypothyroid
_____hyperthyroid
_____blood sugar low_____high____
_____adrenal fatigue

_____frighten easily
_____anger easily
_____ periods of extreme energy
_____periods of low energy
_____abuse survivor
_____previous counseling
_____ ongoing counseling
_____ poor memory
_____lethargy

SKIN/HAIR/NAILS
_____rashes
_____hives
_____eczema
_____psoriases
_____redness
_____dryness/ oily_____
_____acne
_____fungal infections
_____hair loss
_____premature gray
_____weak nails
_____ridged nails
_____discolored nails

OTHER_____

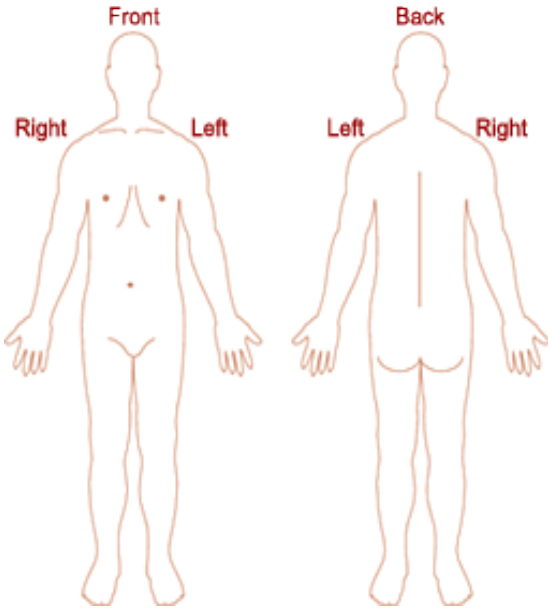
_____

DIET/ NUTRITION
_____meat eater
_____vegetarian
_____dairy
_____grains
_____white flours
_____artifical sugars
_____sugar x_____ per day/week
_____fast food x_____ day/ week
_____caffeine
_____soda Reg_____ Diet _____
_____water-glasses /day____
_____alcohol x _____ day/week___
_____dietary
restrictions_____

_____

LIFESTYLE
_____student fulltime____parttime__

_____sleep hours / night_____
_____exercise x times week____
_____type of exercise_____
_____other



Describe pain and location

- ○ Sharp ○ Burning ○ Aching
- ○ Fixed ○ Other_____

- ○ Sharp ○ Burning ○ Aching
- ○ Fixed ○ Other_____

- ○ Sharp ○ Burning ○ Aching
- ○ Fixed ○ Other

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment, for my self or my child.

Patient or parent signature Date

I have not received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment for myself or for my child. Ohio law requires that a Licensed Acupuncturist recommend that you receive an exam for the condition for which you are requesting treatment from a physician or a chiropractor.

I understand this recommendation

Patient or parent signature Date

Practitioners notes_____
_____

_____
_____

Tongue body_____ Tongue coat_____ Tongue color

TCM Pulse assessment_____
_____

B/P_____

TCM syndrome_____
_____

Treatment plan
_____
_____

_____
Andy Lee RN, LAc