Traditional Chinese Acupuncture
& Wellness Center

New Patient Intake Form

RESET PRINT

Patient Name		**Date of Birth**	**Age**
Address	**City**	**State**	**Zip**
Phone	**Work**	**Cell**	
Best Time/Which # to Call	**Email**		
Social Security Number	**Sex:** Male ___ Female ___	**Marital Status:** Single___ Married___ Divorced___ Widowed___	
Occupation	**Employer & Telephone Number**		
Emergency Contact & Relationship	**Phone**		
Website referral or who referred you?			

PRIMARY INSURANCE	
Name of Insurance Company	**HSA Acct:** Y / N
Address	
Policy #	**Group #**
Subscriber Name	**D.O.B**
Subscriber SS #	
SECONDARY INSURANCE	
Name of Insurance Company	
Address	
Policy #	**Policy #**
Subscriber Name	**Subscriber Name**
Subscriber SS #	

I, undersigned, authorize payment of medical benefits to Traditional Chinese Acupuncture and Wellness Center LLC for any service furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize you to release to my insurance company or their agent, information concerning health care, treatment, or supply provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

Patient Signature Date

New Patient Intake Form

Reason For This Visit:

_____

_____

_____

_____

Approximate Date Started _____ **Describe what caused it** _____

Have you consulted a physician regarding this? ☐ **YES** ☐ **NO**

Please describe in detail:

_____

_____

_____

1) **Allergies:**

_____

_____

2) **List medications you are currently taking:**

_____

_____

_____

_____

New Patient Intake Form

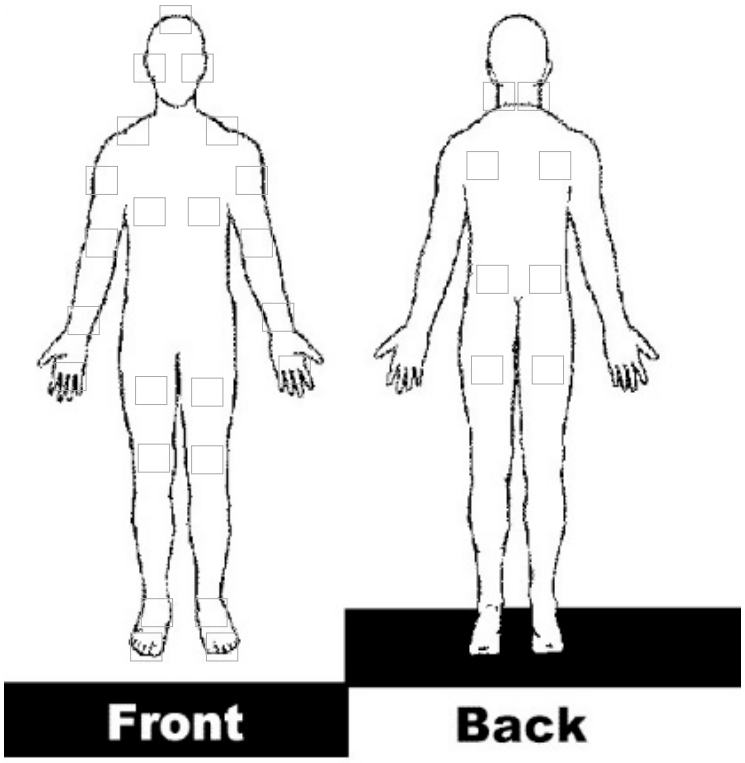
3) **Please mark your discomfort area on the figure on the right as the following:**

Pain: as XX

Numbness: as NN

Pins/Needles: as OO

Area of Treatment



4) **Is the pain/discomfort constant or intermittent (on / off) throughout the day? (select which applies)**

- ☐ constant
- ☐ intermittent

5) **On a scale of zero to ten, with ten being the worst and one being no pain, how would you rate your current pain?**

1	2	3	4	5	6	7	8	9	10

6) **Check any activities that aggravate the pain:**

☐ Walking ☐ Lifting ☐ Coughing ☐ Sitting ☐ Bending ☐ Sneezing ☐ Sleeping

Other: _____

7) **Check any activities that alleviate the pain:**

☐ Rest ☐ Standing ☐ Heat ☐ Exercise ☐ Lying Down ☐ Ice ☐ Sitting ☐ Massage

Other: _____

Tell Us About Your Past Medical History

Please Mark The Check Box If You Previously Suffered From These Conditions.

- ☐ Asthma
- ☐ Colitis
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Gout
- ☐ HIV
- ☐ Hyper Thyroid
- ☐ Mental Illness
- ☐ Pacemaker
- ☐ Polio
- ☐ Kidney Stones
- ☐ Anemia
- ☐ Chronic Fatigue
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Heart Disease
- ☐ Herpes Simplex
- ☐ Hypo Thyroid
- ☐ PTSD
- ☐ STD's
- ☐ Depression
- ☐ Eating Disorder
- ☐ Goiter
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pneumonia
- ☐ Physical Abuse
- ☐ Reynaud's Disease
- ☐ Stroke
- ☐ Other _____

Addictions Cancer?

_____

What Type?

_____

Hospitalization, Operations and Significant Traumas

_____

Tell Us About Your Lifestyle

Diet

_____

_____

Exercise

_____

_____

Mark The Ones That Describe You

- ☐ Sleep After Midnight
- ☐ Smoke Tobacco Daily
- ☐ Drink Coffee Often
- ☐ Smoke Marijuana Often
- ☐ Drink Soda Often
- ☐ Drink Alcohol Often

Recreational Drugs?

_____

_____

Stress Level

_____

_____

Current State of Health

My Body Temperature Feels? ☐ Hot ☐ Cold ☐ Normal

General Symptoms

- ☐ Edema
- ☐ Fever
- ☐ Insomnia
- ☐ Foggy Headed
- ☐ Bruise Easy
- ☐ Body Aches
- ☐ Poor Appetite
- ☐ Fatigue
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Night Sweats
- ☐ Short Of Breath

Head, Eyes, Ears, Nose & Throat Symptoms

- ☐ Difficult to Focus
- ☐ Ear Ringing: High Pitch
- ☐ Mouth Sores/Ulcers
- ☐ Plum Pit Feeling in Throat
- ☐ Sore Throat
- ☐ Floaters
- ☐ Ear Ringing: Low Pitch
- ☐ Grinding Teeth
- ☐ Headaches
- ☐ Migraines
- ☐ Blurry Vision
- ☐ TMJ
- ☐ Poor Hearing
- ☐ Ear Aches

Cardiovascular Symptoms, Signs & Diseases

- ☐ High Blood Pressure
- ☐ Swelling of Hand/Feet
- ☐ Heart Palpitations
- ☐ Irregular Heart Beat
- ☐ Heart Beating Fast
- ☐ Low Blood Pressure
- ☐ Phlebitis
- ☐ Other: _____

GastroIntestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain/Cramp
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Other: _____
- ☐ Hiccup
- ☐ Acid Regurgitation
- ☐ Hemorrhoids

Genitourinary

- ☐ Frequent Urination
- ☐ Genital Sores
- ☐ Premature Ejaculation
- ☐ Enlarged Prostate (Men)
- ☐ Incomplete Urination
- ☐ Wakes Up To Urinate
- ☐ Libido
- ☐ Genital Itching
- ☐ Unable to Hold Urine
- ☐ Decrease Flow
- ☐ Pain During Urination
- ☐ Other: _____
- ☐ Smelly Urine
- ☐ Bedwetting
- ☐ Decrease Stream Power
- ☐ Wet Dreams
- ☐ Dark Yellow Urine
- ☐ Urinary Tract Infection
- ☐ Low Semen Volume (Men)
- ☐ Impotence (Men)
- ☐ Kidney Stones

Gynecological & Obstetrics (Women Only)

- ☐ Currently Pregnant
- ☐ Uterine Fibroids
- ☐ PMS
- ☐ Ovarian Cysts
- ☐ No Menstrual Cycle
- ☐ Irregular Menses
- ☐ Vaginal Sores
- ☐ PID
- ☐ PCOS
- ☐ Endometriosis
- ☐ Menstrual Clots
- ☐ Frequent Yeast Infections

Gynecological

Last Menstrual Period

_____

Date of Last PAP

_____

Age Menses Started

_____

Number of Days Between Periods?

_____

How Many Days Do You Bleed (During Period)?

_____

Menstrual Blood Clots

_____

Color of Menstrual Blood

_____

What is Your Flow Like?

_____

Irregular Menses

_____

Mid-Cycle Bleeding?

_____

Menopause

_____

Birth Control

_____

Breast Lumps

_____

Vaginal Discharge

_____

Obstetrics

How many months pregnant?

_____

Previous Live Births?

_____

Any Miscarriages?

_____

Previous Abortions?

_____

IVF

_____

Frequent Emotions

- ☐ Fear
- ☐ Grief
- ☐ Worried
- ☐ Depression
- ☐ Anxiety
- ☐ Anger
- ☐ Suicidal
- ☐ Irritable
- ☐ Manic

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable 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. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.
While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter).

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

X_____
Signature of Patient or Personal Representative

_____ _____
Print Name of Patient or Personal Representative Relationship of Personal Representative to Patient

_____
Date