

To: New patients for acupuncture and Oriental medicine

Thank you for your interest in becoming an acupuncture and Oriental medicine patient. As part of your first visit to our clinic, you will take part in a comprehensive interview covering all aspects of your well-being. In preparation for the initial visit, please complete the enclosed intake form and bring it with you to your appointment. This allows you to complete the form at your leisure. Please try to be as thorough as possible. If you have questions, or concerns, you may email them to VBacupuncture@gmail.com or simply wait for your appointment and discuss them with your acupuncture clinician.

We look forward to participating in your health care.

PATIENT INFORMATION

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Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Significant Other
 Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Emp. Address _____

Emp. Phone _____

Spouse/Partner's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse/Partner's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

H _____ W _____ Cell _____

Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home phone _____ Work phone _____

GENERAL INFORMATION

Have you had acupuncture before? Yes No Have you used Chinese herbal medicine? Yes No

Are you currently under the care of a physician? Yes No If Yes, for what? _____

Physician's name: _____

Physician's phone: _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to

_____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

ORIENTAL MEDICINE INTAKE FORM

Name: _____

Date: _____

PRESENT HEALTH CONCERNS: Please list your most important health concerns in order of their significance.

1. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____

2. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____

3. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please list **allergies** that you have to any of the following:

Drugs: _____ Foods: _____

Other (i.e. pollen, paint, etc.): _____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

Personal Habits:

Tobacco packs/day _____

Alcohol drinks/wk _____

Coffee/tea/cola cups/day _____

Recreational drugs times/wk _____

High Stress Level Reason _____

Do you follow any diet regimens/restrictions?

Yes No

If Yes, describe: _____

Work Activity:

Sitting % of time _____

Standing % of time _____

Light labor % of time _____

Heavy labor % of time _____

Exercise:

Do you exercise regularly? Yes No

If Yes, describe & tell how

often: _____

FAMILY INFORMATION

Do you have children? Yes No If Yes, how many? _____ Ages _____

Are you, or could you be currently pregnant? Yes No Due date _____

Please check if you have had (in the **last three months**)

GENERAL

- | | | |
|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fevers/Chills | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Poor sleeping |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Heavy sleeping |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Bleed / bruise easily | <input type="checkbox"/> Dream disturbed sleep |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Peculiar tastes | (time?) | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Fatigue | |

SKIN AND HAIR

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes/Hives | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Fungal infections |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Change in hair or skin texture |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Pimples/Acne | |

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | |
|---|--|---|
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Earaches/Infections | <input type="checkbox"/> Sores on lips/tongue |
| <input type="checkbox"/> Eye strain/pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Excessive saliva |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Excessive phlegm – color_____ | <input type="checkbox"/> TMJ disorder |
| <input type="checkbox"/> Poor/blurry vision | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Recurrent sore throats | |
| <input type="checkbox"/> Cataracts/Glaucoma | | |
| <input type="checkbox"/> Headaches (location, triggers, severity)? | | |

Other head & neck concerns:

CARDIOVASCULAR

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | |

Other heart or blood vessel concerns:

RESPIRATORY

- | | |
|---|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Tight chest |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Production of phlegm - color?_____ |
| <input type="checkbox"/> Bronchitis | Is it <input type="checkbox"/> thick or <input type="checkbox"/> thin |
| <input type="checkbox"/> Pneumonia | |

Other lung related concerns:



GASTROINTESTINAL

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Belching | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Itchy anus |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Burning anus |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Black stools | <input type="checkbox"/> Hemorrhoids/fissures |
| <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Mucus in stools | |
| <input type="checkbox"/> Hiccups | <input type="checkbox"/> Acid Regurgitation | |

History of chronic laxative use?

Other concerns with your general digestion:

GENTIO-URINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Nocturnal emissions |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Frequent urinary tract infections |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Chronic yeast infection |
| <input type="checkbox"/> Decrease in flow | | |

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- | | | |
|---|---|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Cramps/spasms | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> General joint pain/stiffness | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Hand/wrist pains | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Joint with limited range of motion_____ |
| <input type="checkbox"/> Muscle pains | | |

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Concussion | <input type="checkbox"/> History of emotional/physical abuse |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Irritability | |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses_____ If no longer menstruating, approximate date ceased_____

First day of last menses_____ Length between menses:_____days Duration of period:_____days

- | | | |
|---|---|--|
| <input type="checkbox"/> Unusual flow (<input type="checkbox"/> heavy or <input type="checkbox"/> light) | <input type="checkbox"/> Clots in flow | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal discharge – color_____ | <input type="checkbox"/> Vaginal sores |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Hot flashes |
| | | <input type="checkbox"/> Breast lumps/soreness |

GYNECOLOGY (continued)

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP: _____ Results were: normal abnormal unsure
If you use birth control, what type & for how long?Have you ever used hormonal methods for contraception or period regulation?
(i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

PREGNANCY HISTORYNumber of pregnancies _____ Births _____ Miscarriages _____ Abortions _____
Were your births relatively normal? Explain:

Other related concerns:

COMMENTS

Please let us know of any other concerns you would like to address:

Family History: Please fill in the boxes for each condition that applies to one of your family members.

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			