Natural Healing Ways

INTEGRATED MEDICINE AND ACUPUNCTURE

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PATIENT INTAKE FORM

Date: ________________

Personal Information

____

First Name *Last Name* *Date of Birth* *Sex* *Social Security Number*

____

Address *City* *State* *Zip Code* *Email*

(______) ____________________

Phone 1 ☐ Home ☐ Mobile ☐ Work

☐ Single ☐ Married ☐ Widowed

Height ______'______" What is your normal weight range? _______-_______ *lbs.* How much do you weigh currently? _______*lbs.*

Insurance Information

____

Insurance Company *ID#* *Contact Number*

______________________________/___/________________________ ☐ Spouse ☐ Dependent

Primary Insured Name *Date of Birth*

Reason For Visit

☐ New Patient ☐ Headaches ☐ Adjustment ☐ Back Pain ☐ Consultation

☐ Returning Patient ☐ Sciatica ☐ Injury ☐ Report of Findings ☐ Auto Accident

☐ Chronic Pain ☐ Menopause ☐ Other ____

Referred By/How Did You Hear About Natural Healing Ways?

☐ Provider/Insurance ☐ Friend/Family ☐ Web Search ☐ Walk In ☐ Other

Name of the person who referred you:____

Emergency Contact Information

____

Full name *Relationship*

____

Phone 1 ☐ Home ☐ Mobile ☐ Work

Complaints: List your chief complaint first

1. ______________________________ 2. ______________________________ 3. ______________________________

Does the pain travel anywhere else? If yes, where? ______________________________

Do you know what caused the problem? If yes, what? ______________________________

Do you notice the pain during a certain time of day? If yes, what time? ______________________________

Frequency: ______________	Times per	☐ Day	☐ Week	☐ Month	☐ Year
Duration: ______________	Pain Lasts	☐ Minutes	☐ Hours	☐ Days	☐ Other ___
Onset: Have had symptoms over the past		☐ Days	☐ Weeks	☐ Months	☐ Years
Intensity:		☐ Minimal	☐ Slight	☐ Moderate	☐ Severe
Is your condition:		☐ Better	☐ Worse	☐ Same	☐ Different

Rate your pain: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 being no pain at all and 10 being the worst imaginable

Type of pain, please describe:

☐ Aching	☐ Burning	☐ Cramping	☐ Deep	☐ Dull	☐ Numb
☐ Radiating	☐ Sharp	☐ Shooting	☐ Sore	☐ Stiff	☐ Tight
☐ Tingling	☐ Throbbing	☐ Swelling	☐ Stabbing	☐ Other: ______________	

Have you been given a diagnosis for this problem? If so, what was the diagnosis? ______________________________

____

What treatments have you tried for your condition?

☐ None ☐ Acupuncture ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Medication

Any other treatments? ______________________________

To ensure you receive a complete and thorough evaluation, please provide us with some important background information. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Please list your leisure activities: ______________________________

Please check any of the following caregivers whose care you're under now or have been under within the last 6 months:

☐ Medical Doctor (MD)	☐ Dentist	☐ Psychiatrist/Psychologist	☐ Chiropractor
☐ Osteopath	☐ Physical Therapy	☐ Homeopath	☐ Other: ______________

Date of last physical examination: ______________

If you have seen any of the above during the past three months please describe for what reason (illness, medical condition, physical, etc.): ______________________________

Have you EVER been diagnosed as having any of the following conditions? *Please check if yes.*

☐ Cancer, if yes what kind? ____________________

☐ Heart problems, if yes what kind? ____________________

☐ High blood pressure

☐ Circulation problems

☐ Asthma

☐ Stomach ulcers

☐ Chemical dependency (i.e. alcoholism)

☐ Thyroid problems

☐ Diabetes

☐ Multiple Sclerosis

☐ Rheumatoid Arthritis

☐ Other arthritic condition

☐ Depression

☐ Hepatitis

☐ Tuberculosis

☐ Stroke

☐ Kidney disease, if yes what kind ____________________

☐ Blood clots

☐ Osteoporosis

☐ Other: ____________________

For Office Use Only

Other Information

During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Have you ever been threatened, hurt, made to feel afraid or humiliated by your partner or someone close to you?

☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization.

Surgeries/Hospitalizations include date and reason:

1. ____________________ 2. ____________________

3. ____________________ 4. ____________________

5. ____________________ 6. ____________________

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains, and the approximate date of injury):

Date: _______ Injury: ____________________

Date: _______ Injury: ____________________

Date: _______ Injury: ____________________

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:
Please check if yes.

☐ Yes Diabetes	☐ Yes Cancer	☐ Yes Alcoholism or chemical dependency
☐ Yes Stroke	☐ Yes Kidney disease	☐ Yes Inflammatory arthritis (Rheum./Anky.)
☐ Yes Depression	☐ Yes Heart disease	☐ Yes High blood pressure

If yes, who? ____________________

List any medications, vitamins or herbs you are currently taking?

1. ____________________ 2. ____________________

3. ____________________ 4. ____________________

5. ____________________ 6. ____________________

If you consume caffeinated coffee or caffeine containing beverages, what time of day do you drink them and about how many ounces per day do you drink?

Amount: __________ Time of day: __________

Do you use tobacco? ☐ Yes ☐ No If yes, in what form do you use it (smoke/chew)? __________

How often and how much? __________ How long have you used it? __________

How many days per week do you drink alcohol? If one drink equals one beer, one glass of wine or one mixed drink how much do your normally drink at an average sitting?

Days per week: ________ Amount: __________ Type of alcohol: __________

Do exercise? If so, what do you average in a typical week?

Days per week: ________ Type of Exercise: __________ Minutes in Duration: __________

Meals:

What do you eat for breakfast ____________________

What do you eat for lunch ____________________

What do you eat for dinner ____________________

Please note any of the following that are NEW, UNUSUAL, or ATYPICAL for you:

☐ Weight loss	☐ Weight gain	☐ Fatigue
☐ Nausea/vomiting	☐ Tremors	☐ Double vision
☐ Fever, chills, sweats	☐ Hearing problems	☐ Sexual difficulties
☐ Skin rash	☐ Weakness	☐ Easy bruising
☐ Difficulty breathing	☐ Eye redness	☐ Seizures
☐ Dizziness/ light-headedness	☐ Night sweats	☐ Problems sleeping
☐ Numbness or tingling	☐ Joint/muscle swelling	☐ Excessive bleeding
☐ Joint/muscle swelling	☐ Arm or leg swelling	☐ Regular cough
☐ Heart racing in your chest	☐ Joint/muscle swelling	☐ Constipation/diarrhea
☐ Heartburn/indigestion	☐ Blood in stools	☐ Problems urinating
☐ Post menopause	☐ Urinary incontinence	☐ Blood in urine
☐ Pregnant (or think you might be)	☐ Stress at home or work	

Please indicate all of the following symptoms which reflect your situation.

General Symptoms

☐ Persistent pain at night
☐ Unexplained weight loss
☐ Unwarranted fatigue
☐ Unusual lumps, nodules or growths
☐ Pain or feeling of heaviness in chest
☐ Constant/severe pain in lower leg or arm
☐ Swelling unrelated to injury
☐ Frequent nausea or vomiting
☐ Frequent or severe abdominal pain
☐ Fever or night sweats
☐ Swelling/redness in joints unrelated to injury
☐ Frequent/severe headaches, unrelated to injury
☐ Changes in speech
☐ Problems with balance, coordination or falling
☐ Sudden weakness
☐ Heat sensation in palms/soles of feet
☐ Low-grade fever at night
☐ Insomnia
☐ Nightmares
☐ Dry mouth and/or throat
☐ Deep yellow urine
☐ Cold hands/feet
☐ Asthma
☐ Shortness of breath with exertion
☐ No energy
☐ Depression
☐ Nausea
☐ Sour regurgitation
☐ Edema
☐ Constant pain anywhere in body
☐ Loss of appetite
☐ Dizziness
☐ Shortness of breath
☐ Pulsating pain anywhere in body
☐ Discolored or painful feet
☐ Frequent heartburn or indigestion
☐ Unusual menstrual abnormalities
☐ Change in or problems with bladder function
☐ Recent severe emotional disturbance
☐ Changes in hearing
☐ Problems swallowing
☐ Visual changes (blurriness, loss of sight, etc.)
☐ Fainting spells
☐ Body feeling hot
☐ Low-grade fever in afternoon
☐ Sweating at night
☐ Dream disturbed sleep
☐ Mental restlessness
☐ Thirst
☐ Constipation
☐ Spontaneous sweating
☐ Shortness of breath when lying down
☐ Diarrhea
☐ Poor memory
☐ Anxiety
☐ Vomiting
☐ Abdominal distention
☐ Vaginal discharge

Fei System Symptoms

☐ Nasal obstruction
☐ Yellow/green nasal discharge
☐ Hoarseness, if yes how long?:___________________
☐ Chills ☐ Coughing up sticky sputum/phlegm
☐ Body aches
☐ Prone to catching flu/colds
☐ Hives ☐ Itching of skin
☐ Eczema
☐ Allergies
☐ Mucus in stool
☐ Dry Skin
☐ Watery nasal discharge
☐ Cough
☐ Coughing up yellow/green sputum/phlegm
☐ Coughing bloody sputum/phlegm
☐ Acne
☐ Rashes
☐ Blood in stool
☐ Burning sensation of anus

Xin System Symptoms

- ☐ Feeling of constriction in chest
- ☐ Pain of heart region
- ☐ Heart palpitations
- ☐ Irregular heartbeat
- ☐ Listlessness
- ☐ Manic feeling
- ☐ Sore tongue
- ☐ Fidgetiness
- ☐ History of heart murmur
- ☐ Flushing of face
- ☐ Feeling of agitation
- ☐ Fainting

Pi System Symptoms

- ☐ General fatigue
- ☐ Poor appetite
- ☐ Craving particular foods
- ☐ Sudden drop of energy during the day
- ☐ Muscular weakness of limbs
- ☐ Bearing down sensation of stomach
- ☐ Indigestion
- ☐ Unusual bleeding
- ☐ Skin blotches
- ☐ Non-healing sores
- ☐ Always feeling hungry
- ☐ Feeling of stuffiness in stomach
- ☐ Burning sensation in stomach
- ☐ Bad breath
- ☐ Bitter taste in mouth
- ☐ Sticky saliva
- ☐ Gas
- ☐ Food allergies
- ☐ Regular bowel movements
- ☐ Not regular bowel movements
- ☐ Recent changes in bowel movement habits
- ☐ Hemorrhoids
- ☐ Frequency of bowel movements _____________ times per________
- ☐ Uterine bleeding
- ☐ Bleeding gums

Shen System Symptoms

- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Hair loss
- ☐ Problems with teeth
- ☐ Grinding of teeth
- ☐ Aversion to cold
- ☐ Achy bones
- ☐ Soreness of lower back
- ☐ Cold sensation in back
- ☐ Soreness /weakness of knees
- ☐ Frequent urination
- ☐ Clear, watery urination
- ☐ Prolapse of uterus
- ☐ Wake up to urinate ______ times per night
- ☐ Do not wake up to urinate
- ☐ Bed wetting
- ☐ Cloudy urine
- ☐ Urgency to urinate
- ☐ Dark yellow urine
- ☐ Burning of urethra
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Incontinence
- ☐ Infertility
- ☐ Loss of sexual desire
- ☐ Infertility

Gan System Symptoms

- ☐ Seizures
- ☐ Feeling of distention of head
- ☐ Headaches
- ☐ Vertigo
- ☐ Painful eyes
- ☐ Blurry vision
- ☐ Itchy eyes
- ☐ Cataract
- ☐ Glaucoma
- ☐ Color blindness
- ☐ Belching
- ☐ Churning feeling of stomach
- ☐ Muscle spasms
- ☐ Tremors of extremities
- ☐ Brittle finger/toenails
- ☐ Moodiness
- ☐ Sighing
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability

Gan System Symptoms (Cont.)

☐ Night blindness
☐ Nose bleeds
☐ Feeling of distention of abdomen
☐ Vomiting of blood
☐ Hiccups
☐ Easily susceptible to stress
☐ Ever been under care of counselor/psychiatrist
☐ Ever felt suicidal
☐ Ever attempted suicide

Three words which describe your emotions: ____

Gynecological Information

Number of pregnancies: ______ **Live births** _____ **Premature births** ________ **Abortions** _______ **Miscarriages** ______

Are you pregnant now? ☐ Yes ☐ No ☐ Possibly

☐ I have regular cycles
☐ I do not have regular cycles
☐ I have painful periods
☐ Age of first period ___________

Length of cycle ________________________
Duration of cycle ______________________
Date of last GYN Exam______Results______
Date of last period _____________________

Do you experience any of the following with menstrual cycle?

☐ Breast Distention
☐ During cycle experience changing emotions
☐ Excessive bleeding
☐ Dark menstrual blood
☐ Menstrual blood with clots
☐ I do breast exams
☐ I do not use birth control
☐ Other ___________
☐ Before ☐ During
☐ Very scanty bleeding
☐ Watery menstrual blood
☐ Bleeding between periods
☐ I do not do breast exams
☐ My birth control of choice is: ________________________________

INFORMED CONSENT TO ACUPUNCTURE AND CARE

I hereby request and consent to the performance of acupuncture treatments, the prescription of herbal remedies 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 named above and/or other licensed acupuncturists who now, or in the future, trat me while employed by, work with, and are associated with, or serve as a back-up for the acupuncturist named above, including those working at the clinic or office listed above or any office or clinic, whether signatories to this form or not.

I have been informed that acupuncture and herbal remedies have the effect of normalizing physiological functions and modifying pain, and are employed to treat certain diseases. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, slight bleeding or tingling near the needle site that may last for a few days.

I understand that only disposable needles are used in this clinic to minimize possible infections. There have been rare instances reported of fainting, infection or scarring. There have been extremely rare instances of reported spontaneous miscarriages, pneumothorax or death.

I have been informed that herbs are a safe method of treatment. However, I understand that herbal remedies occasionally may cause dizziness, nausea, vomiting, diarrhea, or constipation. Modifying or stopping the herbal remedy usually reverses these side effects. In extremely rare circumstances herbal remedies may cause irreversible damage and death.

I have had an opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture and herbal remedies. I understand that results cannot be guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgement on the best course of treatment based on the facts then known.

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

____ ___________________________

Signature of Patient or Patient’s Representative Date signed.

____ ___________________________

Print Name of Patient or Patient’s Representative Date signed

Release of Information to Process Insurance Claim

I hereby grant permission to the acupuncturist named and support staff to release all necessary information to my insurance company to process my insurance claim.

____ __________________

Signature of Patient or Patient’s Representative Date signed

Missed Appointment agreement

I understand that unless I cancel my appointment at least 24 hours in advance. I will be charged the full amount for the missed appointment. I understand that my insurance will not cover these charges.

____ __________________

Signature of Patient or Patient’s Representative Date signed