LEGACY ACUPUNCTURE

New Patient Intake Form

Please print clearly and bring with you to the office for your first visit. All records are confidential.

First Name _____ Date _____

Last Name _____ Birth Date _____ Age _____

Address _____ M F Ht. _____Wt. _____

_____ Occupation _____

City _____

State _____ ZIP Code _____

Home Phone (_____) _____ Work Phone _____

Cell Phone (_____) _____ Email _____

Emergency Contact (Name & Number) _____

Referred By _____

Primary Care Physician _____ Phone (_____) _____

Chief Complains (reasons for visit)

_____

_____

_____

How important is this problem (medical issue e/etc.) to you? (Ex. 10% - 100%) _____

List all previous treatments for this condition (including medication) _____

_____

_____

Other Medical Issues _____

_____

Current Medication/Supplements _____

_____

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Past Medical History: (check all that apply and include medication)

AIDS/HIV_____ Diabetes Mellitus _____ Herpes (oral, genitals_____

Rheumatic Fever_____ Stroke_____ Tuberculosis_____

Chest pain _____ Glaucoma _____ Cancer _____

Asthma _____ Hepatitis (type) _____ High blood pressure _____

Pneumonia _____ Seizures _____ Thyroid disorder (type) _____

Ulcers _____ Depression_____

List any previous surgery/ major trauma (include dates)

_____

_____

Family History: (list major medical conditions)

Father:_____

Mother:_____

Siblings:_____

LIFE STYLE

Do/Did you smoke? Yes/No Cigarettes_____ Pipe_____ Cigars_____ Vaping_____

#. Of years _____ How much? _____. Year quit _____

Do/Did you drink alcohol? Yes /No Do/Did you use recreation drugs? Yes/No

What type/ How often? _____ What Type/ How often? _____

Do you regularly drink coffee/soda/diet/energy drinks? Yes/No How many cups /cans per day? _____

How stress are you? 1 (not stressed) – 10 (extremely stressed) 1 2 3 4 5 6 7 8 9 10

Why? _____

Do you exercise? _____ Type_____ # of hours of sleep _____ Bedtime _____ Awaken ____

Describe your diet:

Breakfast _____ Food Allergies _____

Lunch _____ Food Cravings _____

Dinner _____ Water consumption/day _____

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GENERAL SYMPTOMS: Please Check All That Apply,

- ☐ Poor/ increased appetite
- ☐ Weight loss/ gain
- ☐ Fatigue
- ☐ Irritable/depressed/ anxious
- ☐ Prefer hot/ cold drinks
- ☐ Sweat easily
- ☐ Night sweating
- ☐ Fever/ chills
- ☐ Cold hands/ feet
- ☐ Poor circulation
- ☐ Numbness & tingling in hands/ feet
- ☐ Muscle cramps/ weakness
- ☐ Bruise easily/ bleed
- ☐ Dry skin
- ☐ Itchy skin
- ☐ Rashes/ eczema/ psoriasis/ acne
- ☐ Headache/ migraine
- ☐ Dizziness/ vertigo
- ☐ Blurred vision
- ☐ Eye pain/ tear/ red/ itch
- ☐ Facial pain
- ☐ Sinus disorder/ pain/ pressure
- ☐ Runny nose
- ☐ Swollen glands
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Sore throat
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Gum/ teeth problems
- ☐ Hair loss
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Low blood pressure
- ☐ Diarrhea
- ☐ Loose stools
- ☐ Constipation
- ☐ Blood/ mucous in stools
- ☐ Intestinal cramping
- ☐ Hemorrhoids
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Blood in urine
- ☐ Pain/ burning urination
- ☐ Cloudy urination
- ☐ Incontinence
- ☐ Night urination
- ☐ Urinary infections
- ☐ Neck/ shoulder pain
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Rib pain
- ☐ Difficulty falling asleep
- ☐ Awaken at night
- ☐ Nightmares
- ☐ Asthma/ wheezing
- ☐ Dry/ hacking cough
- ☐ Colored phlegm
- ☐ Copious/ sticky/ bloody phlegm
- ☐ Environmental allergies
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Indigestion
- ☐ Gas/ flatulence bloating
- ☐ Belching/ burping
- ☐ Acid regurgitation
- ☐ Nausea/ vomiting
- ☐ Foul breath

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GYNECOLOGY (WOMEN):

Date of last pap smear _____

Results _____

Date of last menstrual period _____

Length of cycle (regular/ irregular) _____

Duration of flow _____

Age of menopause _____

Do you have clots with menstrual flow _____

Menstrual cramping/ pain _____

Age of menopause _____

Endometriosis _____

Pregnancies _____ Births _____

PMS_____

- ☐ Breast tenderness
- ☐ Mood changes
- ☐ Lower back pain
- ☐ Bloating

Urology (MEN):

Date of last prostate exam _____

Results _____

- ☐ Poor stream flow
- ☐ Premature ejaculation
- ☐ Night urination
- ☐ Frequent urination
- ☐ Low libido

LEGACY ACUPUNCTURE

Acupuncture Center Informed Consent to Treat and Payment Agreement

I hereby request and consent to the performance of acupuncture treatments and the 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 who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist including those working at the clinic or office listed above or any other office or clinic.

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 immedi-ately notify a member of clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including 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 lamp. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 results are not guaranteed.

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. By voluntarily signing below, I show that I have read 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 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.

Initials_____

Payments We request payment at the time of services rendered. Prepayment will be required for future visits that have previous unpaid balances. Should you discontinue care or be released from further service at our office, all outstanding balances will be due. Our office only accepts cash and all major credit cards.

Initials_____

In signing below, I understand all these policies and agree to pay for treatments accordingly and agree that I am responsible for any unpaid balances. Additionally, I understand that this letter supersedes any previous telephone or other verbal communication about office policies and fees. I understand that Acupuncture Center may report me to a credit-reporting agency or take legal action as necessary to be paid for services rendered.

Patient Signature _____ **Date**_____