

### 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 Complaints (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) \_\_\_\_\_

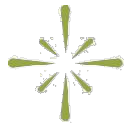
\_\_\_\_\_  
\_\_\_\_\_

Other Medical Issues \_\_\_\_\_

\_\_\_\_\_

Current Medication/Supplements \_\_\_\_\_

\_\_\_\_\_



# LEGACY ACUPUNCTURE

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? \_\_\_\_\_

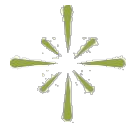
Do you exercise? \_\_\_\_\_ Type \_\_\_\_\_ # of hours of sleep \_\_\_\_\_ Bedtime \_\_\_\_\_ Awaken \_\_\_\_\_

Describe your diet:

Breakfast \_\_\_\_\_ Food Allergies \_\_\_\_\_

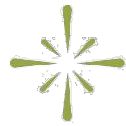
Lunch \_\_\_\_\_ Food Cravings \_\_\_\_\_

Dinner \_\_\_\_\_ Water consumption/day \_\_\_\_\_



**GENERAL SYMPTOMS: Please Check All That Apply,**

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



### GYNECOLOGY (WOMEN):

Date of last pap smear \_\_\_\_\_

Endometriosis \_\_\_\_\_

Results \_\_\_\_\_

Pregnancies \_\_\_\_\_ Births \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

PMS \_\_\_\_\_

Length of cycle (regular/ irregular) \_\_\_\_\_

Breast tenderness

Duration of flow \_\_\_\_\_

Mood changes

Age of menopause \_\_\_\_\_

Lower back pain

Do you have clots with menstrual flow \_\_\_\_\_

Bloating

Menstrual cramping/ pain \_\_\_\_\_

Age of menopause \_\_\_\_\_

### Urology (MEN):

Date of last prostate exam \_\_\_\_\_

Results \_\_\_\_\_

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



## 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 immediately 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** \_\_\_\_\_