PATIENT INTAKE FORM

Name:_______________________________________ Date:_____________________

Street:_____________________________ City:____________________ State:_______ Zip:_________

Home Phone:________________ Work Phone: _________________ Other Phone: _______________
* To receive our occasional newsletter with special offers, please print your email address clearly.

E-Mail Address:_______________________________________ In Emergency Notify:_______________

Primary Physician:_____________________________ Referred By:_____________________________

Age:________ Height:_________ Weight:__________ Date Of Birth:_____________________________

Occupation: __________________________________ Employer: ______________________________

_____ Married _____ Single _____ In A Relationship # Of Kids _________ # Living At Home _________

Other Health Care You Currently Receive: ____

Reason For Seeking Treatment: ____

Anything Else You Want To Address: ____

Have You Had Acupuncture Before? ___ Yes ___ No Do You Exercise? ___ Yes ___ No

Do You Smoke? ____ Yes ____ No How Much? ____

Coffee Per Day ______________ Sodas Per Day ____________ Alcohol Per Day ________________________

Diet: Regular ____ Greasy ____ Spicy ____ Dairy Products _____ Other: __________________________

YOUR PAST MEDICAL HISTORY

- ❑ Heart disease
- ❑ Diabetes
- ❑ Cancer
- ❑ Asthma
- ❑ Alcoholism
- ❑ Stroke/Seizures
- ❑ High/Low blood pressure
- ❑ HIV, Hepatitis
- ❑ Allergies, if so to what:
  ____
- ❑ Other:
  ____
  ____
- ❑ Medications and supplements:
  ____
  ____
  ____
- ❑ Accidents or trauma:
  ____
  ____
- ❑ Past surgeries:
  ____

FAMILY PAST MEDICAL HISTORY

- ❑ Heart disease
- ❑ Diabetes
- ❑ Cancer
- ❑ Asthma
- ❑ Alcoholism
- ❑ Stroke/Seizures
- ❑ High/Low blood pressure
- ❑ Other: __________________________

GENERAL HEALTH INDICATIORS

- ❑ Appetite: poor / heavy / changes / cravings
- ❑ Weight: gain / loss
- ❑ Sleep: insomnia / disturbed / sleeps heavily
- ❑ Fatigue
- ❑ Sweat: sweats easily / night sweats
- ❑ Strong thirst
- ❑ Cold: hands / feet / back / abdomen
- ❑ Chills / Fever
- ❑ Poor coordination / poor balance
- ❑ Tremors
- ❑ Bleeds or bruises easily
- ❑ Other unusual or abnormal conditions:

SKIN AND HAIR
- ❑ Rashes / Ulcers / Hives / Itching
- ❑ Eczema / Psoriasis
- ❑ Hair loss
- ❑ Other conditions:

HEAD, EYES, EARS, NOSE, THROAT
- ❑ Dizziness
- ❑ Spots in eyes
- ❑ Headaches
- ❑ Eye pain
- ❑ Poor vision / Night blindness
- ❑ Blurry vision
- ❑ Ringing in ears / Poor hearing
- ❑ Ear aches / infections
- ❑ Sinus problems
- ❑ Dry mouth / Copious saliva
- ❑ Grinding teeth
- ❑ Recurrent sore throats
- ❑ Nose bleeds
- ❑ Teeth problems / Gum problems
- ❑ Jaw clicks / Facial twitches

Other conditions:

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Fainting
- ❑ Swelling of hands / feet
- ❑ Irregular heartbeat

Other conditions:

GASTROINTESTINAL
- ❑ Nausea / Vomiting
- ❑ Diarrhea / Constipation
- ❑ Gas / Belching / Indigestion
- ❑ Bad breath
- ❑ Rectal pain / Hemorrhoids
- ❑ Abdominal pain / cramps

Other conditions:

RESPIRATORY
- ❑ Cough / Coughing blood / Cough w/ sputum
- ❑ Bronchitis Asthma / Wheezing
- ❑ Pneumonia

Other conditions:

GENITOURINARY
- ❑ Urination: pain / frequency / blood / urgency
- ❑ Unable to hold urine
- ❑ Low / High sex drive
- ❑ Difficulty / Painful erections
- ❑ Prostate trouble

Other conditions:

GYNECOLOGICAL

Age of first period: _____
How often do you have a period: _______
How long do periods last: _____
# of pregnancies: _____
# of deliveries: _____

- ❑ C-sections / Difficult births
- ❑ Fertility treatments
- ❑ Irregular menses
- ❑ Menstrual clots
- ❑ Unusual discharge / Vaginal odor
- ❑ PMS / Cramps / Back pain
- ❑ Fibrocystic breasts

Other conditions:

NEUROPSYCHOLOGICAL
- ❑ Dizziness / Loss of balance / Seizures
- ❑ Areas of numbness
- ❑ Poor memory / Poor concentration
- ❑ Depression / Anxiety / Irritability
- ❑ Easily susceptible to stress
- ❑ Treated for emotional problems

Other psychological problems:

MUSCULOSKELITAL
- ❑ Pain: Neck / Back / Knee / Foot / Ankle / Hand / Wrist / Shoulder / Hip / Muscles
- ❑ Muscle weakness

Other joint or bone problems:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

It is our policy to protect your medical records. We will not release information from your medical record without your consent. Your signature below acknowledges you have received information regarding our privacy practices.

Please Print Name Here	Signature	Date

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I request and consent to the performance of the following on myself (or the person named below for whom I am legally responsible) by the licensed acupuncturist associated with Wimberley Acupuncture PLLC: Acupuncture and other oriental medical procedures including: diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as massage, acupressure, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle counseling

I have had an opportunity to discuss with my professional practitioner the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that acupuncture and other Oriental Medicine procedures have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that these risks are unlikely to occur, but they are possible. Risks may include but are not limited to: bleeding, bruising, pain or strong sensation at the location of needle insertion, punctured organs, nerve pain, burns, aggravation of current symptoms, new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries and strokes. I wish to rely on the professional practitioner to exercise judgement during the course of my treatment, as appropriate at the time, based on the facts known, to be in my interest. I authorize the performance of necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent. I have also had an 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 treatment for my present condition and for any future condition(s) for which I seek treatment.

____________________	____________________	____________
Client's Name (please print)	**Client's Signature**	**Date Signed**

I (name)_________________ am notifying Wimberley Acupuncture PLLC of the following:

Yes I have___ No I have not___ been evaluated by a physician, dentist or nurse practitioner for the condition being treated within 12 months before the acupuncture was performed. **I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.**

OR

Yes I have___ No I have not___ received a referral from a chiropractor with the last 30 days for acupuncture. The referral date was _______________, and the most recent chiropractic treatment prior to acupuncture was _______________. If after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

Client's Signature__________________________________ Date _________________