

Acupuncture For Life

2121 School Rd.

Hatfield, PA 19440

267-575-0592 or 215-361-1619

Patient Intake Form

Name (last, first) _____ Date _____

Address _____

City / State / Zip _____

Home phone _____ Work Phone _____ Cell Phone _____

Email _____ Occupation _____ Birth Date _____

Emergency contact _____ (name & phone) Referred by _____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed

___ Caregiver for dependent ___ Children _____

Have you ever had acupuncture? _____ If yes, when/where?

_____ For what condition?

Are you currently under the care of a physician? _____ If so, who, and for what condition(s)? _____

Main reason(s) for seeking acupuncture?

How long have you experienced symptoms? _____

Your condition is improved by:

Your condition is aggravated

by: _____

List all current medications, prescribed or over the counter

List all current vitamins, herbs and other supplements

Significant illnesses (please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Thyroid | |

Please list any surgeries you've had including dates _____

Please list any Allergies _____

Please list any major emotional or physical traumas you've experienced

Lifestyle (please check all that apply, and note frequency of use)

- Tobacco
- Alcohol
- Recreational drugs
- Caffeinated beverages

Do you exercise? _____ Please list types of activity and frequency:

Dietary preferences

- | | |
|--|---|
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Fast food/ burgers/ fries |
| <input type="checkbox"/> Raw foods diet | <input type="checkbox"/> Spicy / hot |
| <input type="checkbox"/> Low fat diet | <input type="checkbox"/> Sweet |
| <input type="checkbox"/> High protein/low carb | <input type="checkbox"/> Sour |
| <input type="checkbox"/> Dairy /milk /cheese | <input type="checkbox"/> Salty |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Cold drinks |
| <input type="checkbox"/> Chicken | <input type="checkbox"/> Hot drinks |
| <input type="checkbox"/> Fish / seafood | <input type="checkbox"/> Ice chewing |
| <input type="checkbox"/> Red meat | <input type="checkbox"/> Extreme thirst |
| <input type="checkbox"/> Artificial sweeteners | <input type="checkbox"/> Thirst with no desire to drink |

General symptoms

- Fatigue
- Sweat without exertion
- Night sweats
- Fever / chills

- Dizziness / vertigo
- Bleed / bruise easily
- Low immunity
- Other _____

Digestion

- Extreme appetite
- No appetite
- Cravings
- Dieting
- Tired after eating
- Bloating
- Gas
- Acid regurgitation
- Heartburn/Ulcers

- GERD
- Nausea
- Vomiting
- Bulimia
- Anorexia
- Irritability or low energy between meals
- Other _____

How many meals per day? _____ How many snacks per day? _____

Intestinal

- Diarrhea
- Constipation
- Hemorrhoids
- Anal itching / burning
- Laxative use
- Bloody stool
- Mucous in stool
- Anal fissures
- Rectal prolapse

- Intestinal pain/cramping
- Incomplete evacuation
- IBS
- Colitis
- Crohn's Disease
- Gout
- Celiac Disease
- Gallstones
- Other _____

Sleep

- Falls asleep easily
- Lie in bed with eyes open
- Wake as specific times
- Wake repeatedly
- Wake frequently to urinate

- Vivid or Lucid Dreams
- Wake up not feeling rested
- Nightmares or Frightening dreams
- Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat

- Dry eyes
- Spots / flowery vision
- Blurred vision
- Poor vision
- Eye strain
- Night blindness
- Cataracts
- Macular degeneration
- Bleeding gums
- TMJ
- Sores on tongue or mouth
- Dry mouth
- Excess saliva

- Swollen glands
- Earaches
- Difficulty swallowing
- Headaches
- Tinnitus / ringing
- Nosebleed
- Other _____

- Sinus problems
- Post-nasal drip
- Sore throat
- Deafness

Genito-urinary

- Frequent urination
- Loss of urine when laughing or sneezing
- Incomplete urination / retention
- Dribbling
- Burning urination
- Blood in urine

- Wake frequently to urinate
- Kidney stones
- Bedwetting
- Bladder prolapse
- Decreased libido / sexual desire
- Other _____

Men only

- Enlarged prostate/prostatitis
- Prostate cancer
- Testicular cancer
- Testicular pain or swelling

- Erectile dysfunction
- Impotency
- STD's _____

Women only

Age menses began _____ Age menses ended (if applicable) _____

Date of last ob/gyn exam _____

Hysterectomy? partial full

- hormone replacement therapy
- Live births
- Miscarriage
- Abortions
- Infertility
- Birth control pills
- Breast cancer
- Ovarian cysts
- Fibroids
- Endometriosis

- Candida / yeast
- Vaginal discharge
- Vaginal odor
- Vaginal sores
- Herpes
- Human Papilloma Virus positive
- Uterine prolapse
- STD history (chlamydia, PID, etc)
- Fibrocystic breast

Period lasts _____ days Usual number of days in cycle _____

Headaches before menstrual cycle during cycle after cycle

- Pain at ovulation
- Cramps / low back pain
- Acne associated with period
- Constipation associated with period
- Diarrhea associated with period

- Depression or irritability with period
- Bleeding outside of normal menstrual cycle
- No period / skipped cycles
- Irregular cycle

Menstrual flow is:

- Clotting
- Brownish
- Watery, thin and bright red

- Normal red
- Flooding and trickling
- Stop and start flow

If you have been evaluated for infertility, what was your diagnosis?

New Patient Informed Consent

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Acupuncture is NOT a substitute for conventional medical diagnosis and treatment. Techniques commonly employed in the application of acupuncture: Acupuncture needling - treatment will consist of the insertion of sterile disposable needles at specific sites on the body. Stimulation of said needles may be by manipulation, electrical stimulation or the application of warming substances (moxa) on the needle itself. Auxiliary / Associated therapies - massage, acupressure, cupping, gua sha, assisted stretching, and topical application of liniments There is no guarantee that acupuncture will help any condition. Certain medications and social habits may decrease the beneficial effects of acupuncture. These include the use and abuse of alcohol, tobacco, steroids, painkillers, narcotics, stimulants, antidepressants, psycho-pharmaceuticals and illegal drugs.

I, _____, certify that I have read and understood
(Print Name)

the statements above. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

Signature: _____ Date: _____

Payment and Cancellation Policies

Payment is by check, charge or cash. Make checks payable to Acupuncture For Life Full payment is expected at the time the services are rendered. A \$20 charge for the first check returned by the bank. If a second check is returned, subsequent payments must be money order or cash. HCFA forms for insurance reimbursement are available for \$10. If you must cancel your appointment, call as soon as possible to give the Acupuncturist a chance to rebook your time slot. You must call before 5pm the day before your appointment or else you will be charged in full for your cancelled appointment. Exceptions can be made for medical emergencies. If you are an infertility patient and you start your period the day of your appointment, cancel it. You will not be charged for canceling your appointment but please give at least a few hours notice if you can. If Acupuncture For Life must cancel your session for any reason, you will be called by 5pm the day before. If you live alone and have no voice mail or answering machine or other way of contacting you, we will try until 10:00 the evening before your appointment to reach you. If you miss an appointment, you will be charged for it. Payment is expected either at the next appointment or by mail. If for some reason the Acupuncturist misses your appointment, you will, of course, not be charged for it and your rescheduled appointment will be at no charge. In the event of severe winter weather (not flurries), the 5pm cancellation policy is temporarily suspended. Please call Acupuncture For Life as soon as possible if you cannot make your appointment because of the weather. Leave a message on the machine if you have to. The Acupuncturist will do likewise if we can't make your appointment because of the weather. If you have an appointment and you don't call and you don't show up, you will be charged for your appointment regardless of the weather.

I, _____, certify that I have read and understood the statements above
(Print Name)

and agree to abide by them.

Patient Signature: _____ Date: _____

Acupuncturist Signature _____ Date: _____