Healing Arts Acupuncture & Traditional Chinese Medicine

New Patient Intake

Patient Name _____ **Date** _____

General Information

Address _____ City _____ State _____

Home Phone _____ Occupation _____ Zip _____

Work Phone _____ Date of Birth _____

Mobile Phone _____ E-mail _____ Receive email communications/information? ☐Yes ☐No

Emergency Contact _____ Relationship _____ Phone _____

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No How long ago? _____

What was your experience? ☐Very good ☐Good ☐No change ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently seeing another health care provider for your condition? ☐ Yes ☐ No Please identify _____

Are there any other therapies which you are involved in? ☐ Yes ☐ No Please identify _____

Family Physician

Name _____ Phone _____

Address _____

_____

_____ May we contact if necessary to coordinate care? ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

☐ Work	☐ Standing	☐ Sexually	☐ Other
☐ Sleep	☐ Emotional	☐ Recreation	
☐ Walking	☐ Relationships	☐ Bending	
☐ Sitting	☐ Social Life	☐ Stretching	

What have you done about this? _____

_____

Are you interested in:

☐ Pain Relief	☐ Holistic Health	☐ Stress Relief	☐ Other
☐ Preventative Care	☐ Stretching/Yoga	☐ Herbal Therapy	
☐ Oriental Nutrition	☐ Maintenance Care		

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.): _____

List exercise and sport activities you have been or are currently involved in: _____

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what? _____

Do you take medication? ☐ Yes ☐ No If so, what types and how often? _____

Do you take supplements? ☐ Yes ☐ No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ High/low blood pressure	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? _____ Do you have a low point during the day? ☐ Yes ☐ No When? _____

Have you been diagnosed with an arrhythmia? Do you have a pacemaker or other electrical implant?

What are your hobbies/pleasures? _____

Female Concerns

Date of last menstruation _____ Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long? _____

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge Other _____

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other _____

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of _____	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other: _____
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	_____
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	_____
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	_____

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

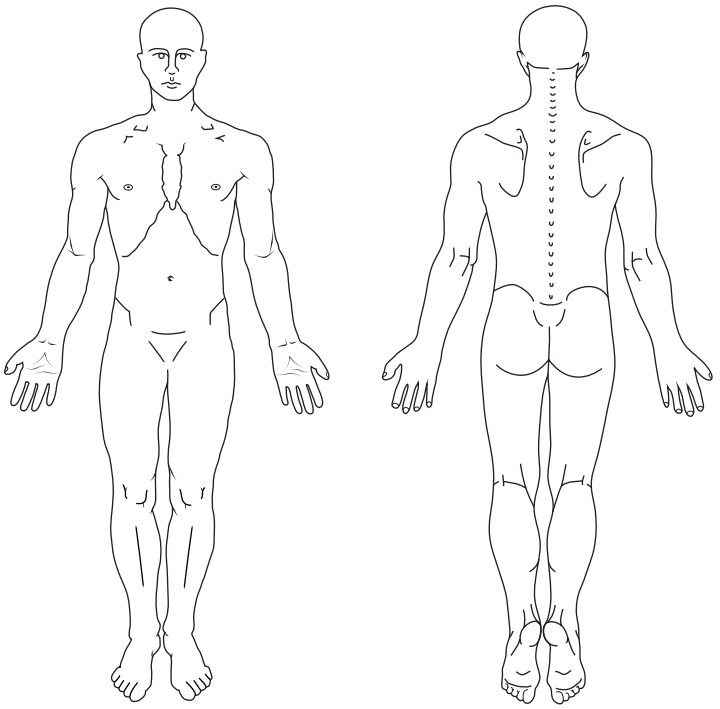
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

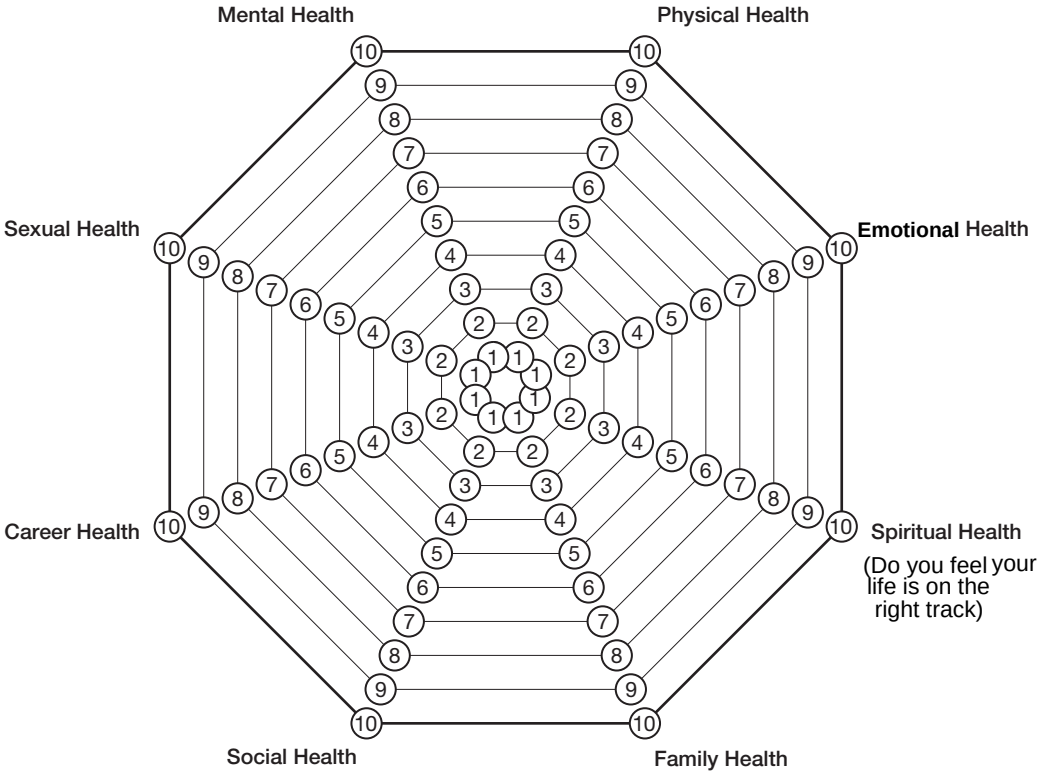
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	X X X X	/ / / /

Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Informed Consent for Traditional Chinese Medicine (TCM) Treatment

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options, methods, techniques, and duration of your therapy. If you have any questions about your treatment, you are encouraged to ask your attending TCM practitioner to further explain any and all pertinent information. Where desired, you are also encouraged to seek the opinions of other health care professionals or to terminate your therapy at any time.

I hereby request and consent to the performance of TCM treatments, and other procedures within the scope of practice for TCM practitioners, on my person by Fang Liu, **R.TCMP, R.Ac** (Registered Traditional Chinese Medicine Practitioner, Registered Acupuncturist)

I understand that methods of treatment may include but are not limited to: acupuncture, cupping therapy, Chinese herbal medicine, the electrical stimulation of acupuncture needles, moxibustion, infrared heat therapy, Chinese medical nutrition and TCM counselling, Chinese medical qigong, Chinese manual medicine (soft tissue manipulation and/or joint manipulation).

I have been informed that acupuncture is considered to be a safe method of treatment but that it may have side effects some of which include bruising, numbness or tingling near the needling sites of potentially a few days' duration, as well as dizziness and/or fainting. I understand that I should not move while the sterile and disposable needles used for my treatment are being inserted, retained, or removed. I have been informed that bruising is also a common side effect of TCM cupping therapy

I understand that a minority of patients may experience pain, stiffness or soreness after the first few days of treatment by Chinese manual medicine (Tuina).

I have been informed that TCM herbs, which may be prescribed for me and which will be derived exclusively from plant and/or mineral sources, are considered to be safe when taken in the dosages and according to the schedules recommended to me by my TCM practitioner but that some may be toxic when taken inappropriately. I understand that the possible side effects of taking such herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I agree to immediately notify my TCM practitioner of any unanticipated or unpleasant effects associated with the consumption of herbs. I also understand that some herbs may be inappropriate for consumption during pregnancy and, therefore, agree to notify my TCM practitioner if I am, or become, pregnant before or during the course of my treatment, as may apply.

I do not expect my TCM practitioner to be able to anticipate and explain all of the potential complications of my treatment beyond a reasonable standard and thus wish to rely on my TCM practitioner's discretion in performing those procedures that she believes to be in my best interests as based upon the information that I provide and the clinical findings obtained at the time of my consultation.

I understand that therapeutic results are not guaranteed.

I understand that authorized medical and/or administrative staff of the clinic may review my medical records and lab reports if necessary, and in accordance with formal confidentiality policies in place at the clinic, but that all of 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, or have had read to me, this consent to treatment, have been told about the risks and benefits of pertinent traditional Chinese medicine therapies and 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 from Fang Liu, R.TCMP, R.Ac.

Patient's Name _____

Patient's Signature_____ **Date Signed** _____

Practitioner's Name **Fang Liu**_____

Practitioner's Signature_____ **Date Signed** _____

Additional information that you would like us to know