

Patient Intake Form

First Name: _____ **Middle Initial:** _____ **Last Name:** _____ **Today's Date:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Email Address: _____ Please add me to your mailing list

Emergency Contact: _____ **Phone Number:** _____ **Relationship to you:** _____

Appointment Confirmations: We will contact you on the business day prior to your scheduled appointment with a reminder.

Please check your preferred location of contact: Home Phone Work Phone Mobile Phone Email

Birth Date: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Gender: Female Male

Marital Status: _____ **Number of Children:** _____ **Ages of Children:** _____

Occupation: _____ **Employer:** _____

Physician's Name _____ **Month/Year of your last doctor visit:** _____

Have you ever received acupuncture before? Yes No

Who can we thank for the referral: A friend A physician Another healthcare practitioner

Their Name: _____

If you weren't referred, how did you find out about us?

Print advertisement (in _____) Brochure (where _____) Online
(search engine _____) Other _____

(continued)

Patient Intake Form (continued)

Reason for today's visit:

Please write a brief description of how this problem began:

How long has it lasted: _____ days weeks months years

Have you had this or a similar condition before? Yes No

Does anything make it better?

Does anything make it worse?

Have you received prior treatment for this condition?

Yes No If yes, when? _____ Where? _____

By whom? _____ What was the diagnosis? _____ What type(s) of treatment were used? _____ Result of that treatment: _____

Current Medications

Name	Dose	Date first started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any major surgeries, accidents, or injuries?

Date: _____ Description: _____

Have you had any of the following illnesses?(check all that apply):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Connective Tissue Disease |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Eye disorders |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Spinal Injury/Problem | <input type="checkbox"/> Neurological Disease |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Other _____ | | |

Do you have any food, drug, or environmental allergies? _____ What are they? _____

Any other health related issue not mentioned above? _____

Family Medical History: (please indicate family member)

- | | | |
|--|--|--|
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Miscarriage _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Alcoholism _____ |
| <input type="checkbox"/> Other _____ | | |

Patient Lifestyle

Name: _____ Occupation: _____

Any **physical strain** at work? Yes No What kind? _____

How many hours do you work per week: _____ Stress levels: Low Medium High

Height: _____ Current Weight: _____

Do you **exercise**? Yes No _____ What kind? _____

How often? _____

Do you smoke? Yes No _____ How many per day? _____ When did you start? _____

Sleep

How much sleep do you typically get? _____ Do you feel rested in the morning?

Yes No Do you have a regular bedtime? Yes No When is it? _____

Do you have a regular wake up time? Yes No When is it? _____

Do dreams disturb your sleep? Yes No Anything else about your sleep? _____

Eating Habits

Meal	Do you eat this meal on most days?	Approximate time:	Foods Eaten:
Breakfast	_____	_____	_____
Lunch	_____	_____	_____
Dinner	_____	_____	_____

Snacking Habits Approximate time _____ Types of food _____

Foods:

Food Type	How often?			
Sodas (regular and diet).....	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Fried Foods (french fires, fried chicken etc.).....	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Several cups of coffee in one day.....	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Donuts, ice cream, cookies, cakes.....	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Milk and cheese.....	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Meat products (chicken, lamb, beef and pork)	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Shellfish.....	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Freshwater and Ocean fish.....	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never

TCM Diagnosis

Check all the symptoms you've had within the past three months

Emotional: I would generally describe myself as: Happy Easy going Restless Irritable
 Indecisive Angry Cry easily Hurried Depressed Stressed out Anxious
 Hard to express emotions Short attention span Other _____

Energy: Fluctuates Low High Lower in the afternoon Normal Tired after meals
 Other _____

Body Temperature: Hot where _____ Cold where _____ Night sweats Hot flashes
 Chilled Flushing Other _____

Digestion: Indigestion Bloating Heartburn Nausea Vomiting Full feeling Belching Gas
 Abdominal pain or cramps Sensitivity to oily foods (upsets your stomach) Bitter taste in mouth
 Gallstones Other _____

Bowels: Frequency: # _____ bowel movements _____ times per day week Loose stools
 Diarrhea Constipation Hemorrhoids Constipation Colon Problems Pain or Cramps
 Using laxatives Other _____

Urination: Frequency of urination: _____ times per day Color: Clear Light yellow Yellow
 Bright Yellow Dark Burning Bladder Infection Urgency Nighttime Incontinence
 Kidney Stones Kidney Infections Other _____

Thirst: Never thirsty Always thirsty Thirsty but doesn't drink Drinks _____ (number of drinks) per day, Temperature preference for drinks: Cold Warm/hot Room Temperature

Cardiovascular: Diagnosed heart problems Palpitations Bleeds easily Low blood pressure
 High blood pressure High Cholesterol Heart Murmur Varicose Veins Ankle Swelling
 Chest Pain: Bruising easily Hands swelling Irregular Heart Beat Other _____

Sleep: Falling asleep: Easy Average Difficult Staying asleep: Easy Average
 Difficult Waking up: Easy Average Difficult Sleep quality: Restless Lots of dreams
 Easily Awakened Nightmares Hard time getting back to sleep

Headaches/dizziness: Headaches Migraines Vertigo Dizziness Motion sickness
 Poor Balance Faints easily Poor memory Other _____

Skin: Dry Hives Itching Oily Acne Rashes Bruise easily Eczema
 Slowly healing cuts Other _____

Hair: Dry Oily Dandruff Falling out Early greying Other _____ (continued)

TCM Diagnosis (continued)

Nails: Soft Spots Ridges/lines Grow slowly Grow fast Purple Pale Break easily
 Other _____

Ears: Poor hearing High pitched ringing Low pitched ringing Discharges Ear aches
 Other _____

Eyes: Wear contacts or glasses Puffy eyelids Dryness Itching Twitches Poor night vision
 Light sensitivity Color Blindness Watery Normal Other _____ Nose
 Congestion Hay fever Frequent sneezing Bleeding Loss of smell
 Sinusitis Rhinitis Normal Other _____

Mouth and Throat: Dry Gum Problems Frequent colds Tight jaw muscles Lump in the throat
 Thyroid problems Grinding teeth Normal Other _____

Respiratory: Short breath Difficulty inhaling Frequent sighing Dry cough Cough with phlegm
 Asthma Bronchitis Emphysema Coughing up blood Tight chest
 Other _____

Pain: Pain anywhere? _____ Location _____ How Long? _____
Quality of pain: Sharp Dull Constant Intermittent What makes it better? Hot Cold
 Movement staying still Other _____ What makes it worse? Hot Cold Movement
 Staying still Other _____

Reproductive Health: Menses: Age of first period _____ How many days long does period last?
_____ Flow: Thick Watery Clots Size of clots if any _____, Cramping, Quality of
Cramping if any Sharp Dull
Vaginal Discharge? yes no Color: Clear White Pale yellow Dark Yellow
Type of birth control used _____ How long _____ Other reproductive
information? _____

Form to be Completed by Patient, Notifying the Acupuncturist of Whether She/He Has Been Evaluated by a Physician, and Other Information:

(Pursuant to the requirements of '183.6(e) of this title (relating to Denial of Licensee; Discipline of Licensee) and Texas Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying
True Nature Acupuncture of the following:

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

(check one) _____ Yes _____ No Initials of patient _____ Date _____

I have received a referral from my chiropractor within the last 30 days for acupuncture. (check one)
_____ Yes _____ No Initials of patient _____ Date _____

After being referred by a chiropractor, 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 whether to follow this advice.

I am seeking acupuncture and Oriental Medicine for one of more of the following: (please circle)

chronic pain weight loss smoking addiction alcoholism substance abuse

Patient or Patient Representative (Print)

Signature Date

Relation to patient (if not patient)

Informed Consent

I hereby request and consent to the performance of oriental medical health care on myself (or the patient named below, for whom I am legally responsible) by Rebecca Hindman L.Ac. or any licensed acupuncturist working with her. I understand that oriental medical health care includes acupuncture, diagnostic techniques such as questioning, pulse evaluation, palpation, observation of range of motion, muscle and orthopedic testing, massage, joint and or viscera manipulation, heat and/or cold therapy, electrical/magnetic stimulation, cupping, recommendation of herbal and homeopathic preparations for ingestion and/or external application, dietary recommendations, and healthy lifestyle counseling.

I understand that there are risks of treatment involved in the practice of Oriental Medicine. I understand and am informed that, as in allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. These risks include but are not limited to bleeding, bruising, nerve pain, punctured organ, aggravation of symptoms, appearance of new symptoms, fainting and fatigue. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgement to be in my best interest based on the known facts at a the time.

I have had the opportunity to discuss with my professional practitioner and/or other clinic personnel the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that Oriental Medicine has helped millions of people, I am also aware that each person is different in their response to acupuncture and that it is possible that I may not see any improvement in my condition or my symptoms may worsen. I understand that no guarantee of cure or improvement in my condition is given or implied.

I have read, or have had read to me this informed consent form. 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 that this consent form cover the entire course of treatment for my present and any future conditions for which I seek treatment with this practitioner.

Patient's name (please print)

Patient's Signature

Patient's representative & relationship to patient

Date

Signature of patient's representative

Appointments

Office Policies

If you need to cancel an appointment we require 24 hours notice. This allows us to to make necessary schedule adjustments. Appointments cancelled with less than 24 hours notice will be charged a \$35 missed appointment fee for that session. If you are more than 20 minutes late for an appointment it will be cancelled and you will be charged for the missed session. Payment for Services Rendered Payment is due at the time of service and can be paid by cash, credit card, or check.

Patient's name (please print)

Patient's Signature

Patient's representative (& relationship to patient)

Date

Signature of patient's representative

Notice of Privacy Policy

I understand that I have the right to review the document “Notice of Privacy Policy” prior to signing this document. This notice has been provided to me in my intake packet.

The Notice of Privacy Policy (Notice) describes the types of uses and disclosures of my “protected health information (PHI)” that will occur in my treatment, payment of bills, or in the performance of healthcare operations of this clinic. My protected health information means health information including my demographic information (name, address, phone number, etc.) that is collected from me and created or received by this clinic or its agents or employees. PHI is information that relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. The Notice also describes other potential releases of my PHI that may occur with or without my authorization, and my rights regarding my PHI.

By signing this form, you consent to our use and disclosure of your PHI as specified in the Notice of Privacy Policy, and acknowledge receipt of the Notice.

PLEASE NOTE: Unless you are claiming insurance for your treatments here, your protected health information (PHI) will NEVER be discussed, verbally or in writing, with anyone but you or your spouse. We will only disclose information to others (i.e. family members, other physicians, etc...) once we have obtained your express written permission. If you wish to keep your information private from your spouse as well, please indicate below.

_____ I wish to keep my PHI (protected health information) private from my spouse.

Patient or Patient Representative (Print)

Signature Date

Patient or Patient Representative (Print)

Signature Date

Relation to patient (if not patient)