AIMC | ACUPUNCTURE & INTEGRATIVE MEDICAL CENTER

New Patient **Intake Form**

Please print clearly and bring with you to the office for your first appointment. All records are confidential.

Name ______________________ Date ______________________

Address ______________________ Birth Date ______________ Age ________

______________________ M F Ht. ____________ Wt. ____________

City/State/ZIP Code

Occupation ______________________

Home Phone (_____) ______________________ Work Phone (_____) ______________________

Cell Phone (_____) ______________________ Email ______________________

Emergency Contact (Name & Number) ______________________

Referred by ______________________

Primary Care Physician ______________________ Phone (_____) ______________________

Other Health Care Practitioners Treating You ______________________

____

Chief Complaint (reason for visit) ______________________

____

____

How important is this problem (medical issue/etc.) to you? (Ex. 10% - 100%) ______________________

List all previous treatments for this condition (including medication) ______________________

____

____

____

Other Medical Issues ______________________

____

____

Current Medication/Supplements ______________________________

____

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

What type/how often? ____________________

Do/did you use recreational drugs? Yes No

What type/how often? ____________________

Do you regularly drink coffee/soda/diet/energy drinks? No Yes How many cups/cans per day? _____

How stressed are you? 1 (not stressed) - 10 (extremely stressed) 1 2 3 4 5 6 7 8 9 10

Why? ______________________________

Do you exercise? _____ Type________________ # hours of sleep ____ bed time ______ awaken ______

Describe your typical diet:

Breakfast ______________________________

Lunch ______________________________

Dinner ______________________________

Food allergies ______________________ Food cravings ______________________

Water consumption / day ______________________________

GENERAL SYMPTOMS: Please check all that apply. (C = Current, P = Past)

C	P		C	P		C	P	
❑	❑	poor / increased appetite	❑	❑	swollen glands	❑	❑	diarrhea
❑	❑	weight loss / gain	❑	❑	sore throat	❑	❑	loose stools
❑	❑	fatigue	❑	❑	difficulty swallowing	❑	❑	constipation
❑	❑	irritable / depressed/ anxious	❑	❑	decreased hearing	❑	❑	blood / mucous in stools
❑	❑	prefer hot / cold drinks	❑	❑	ringing in ears	❑	❑	intestinal cramping
❑	❑	sweat easily	❑	❑	gum / teeth problems	❑	❑	hemorrhoids
❑	❑	night sweating	❑	❑	hair loss	❑	❑	frequent urination
❑	❑	fever / chills	❑	❑	shortness of breath	❑	❑	urgent urination
❑	❑	cold hands & feet	❑	❑	chest tightness	❑	❑	blood in urine
❑	❑	poor circulation	❑	❑	asthma / wheezing	❑	❑	pain / burning urination
❑	❑	numbness & tingling in hands / feet	❑	❑	dry / hacking cough	❑	❑	cloudy urination
❑	❑	muscle cramps / weakness	❑	❑	colored phlegm	❑	❑	incontinence
❑	❑	bruise easily / bleed	❑	❑	copious/sticky/bloody phlegm	❑	❑	night urination
❑	❑	dry skin	❑	❑	environmental allergies	❑	❑	urinary infections
❑	❑	itchy skin	❑	❑	palpitations	❑	❑	neck / shoulder pain
❑	❑	rashes / eczema / psoriasis / acne	❑	❑	irregular heart beat	❑	❑	upper back pain
❑	❑	headache / migraine	❑	❑	low blood pressure	❑	❑	lower back pain
❑	❑	dizziness / vertigo	❑	❑	indigestion	❑	❑	rib pain
❑	❑	blurred vision	❑	❑	gas / flatulence bloating	❑	❑	difficulty falling asleep
❑	❑	eye pain / tear / red / itch	❑	❑	belching / burping			time sleep_____
❑	❑	facial pain	❑	❑	acid regurgitation			awake_____
❑	❑	sinus disorder / pain / pressure	❑	❑	nausea / vomiting	❑	❑	awaken at night
❑	❑	runny nose	❑	❑	foul breath	❑	❑	nightmares

GYNECOLOGY (WOMEN):

date of last pap smear __________ results _______________
date of last menstrual period ______________________________
length of cycle (regular / irregular) ______________________
duration of flow ____
do you have clots with menstrual flow ___________________
menstrual pain / cramping _________________________________
location ____
method of contraception ___________________________________
uterine fibroids ____
type ____

PMS ____
❑ breast tenderness
❑ mood changes
❑ bloating
❑ headache
❑ low back pain
❑ food cravings
ovarian cysts ____
age of menopause ____
endometriosis____
pregnancies________________ births________________

UROLOGY (MEN):

date of last prostate exam __________ results ______________
❑ poor stream flow
❑ premature ejaculation

❑ Night urination
❑ Frequent urination

GENERAL PAIN INDEX QUESTIONNAIRE

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.
ex. 0= completely able to function 10= Totally unable to function

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL

   1 2 3 4 5 6 7 8 9 10

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES

   1 2 3 4 5 6 7 8 9 10

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS

   1 2 3 4 5 6 7 8 9 10

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS

   1 2 3 4 5 6 7 8 9 10

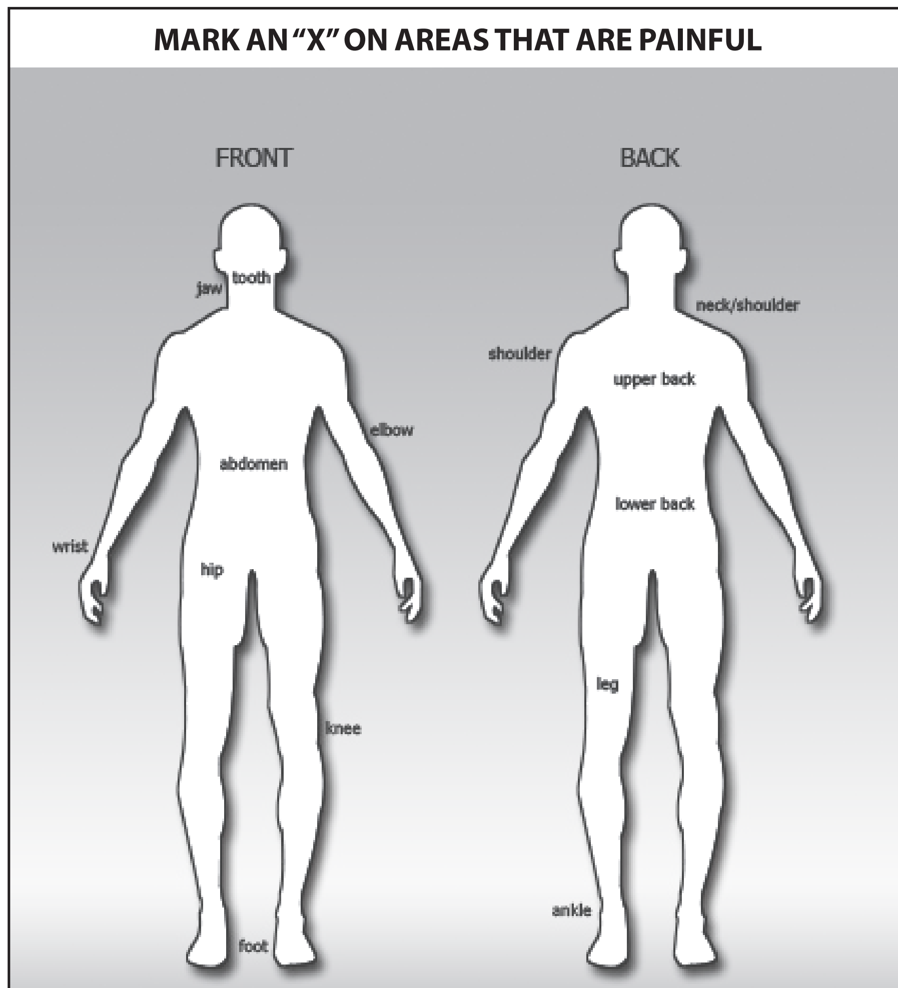
5. **SELF-CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED

   1 2 3 4 5 6 7 8 9 10

6. **LIFE-SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING

   1 2 3 4 5 6 7 8 9 10

MARK AN "X" ON AREAS THAT ARE PAINFUL



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Detoxification **Questionnaire**

Rate each of the following symptoms based on your typical health profile for the past month:

POINT SCALE
- **0**—*Never or almost never* have the symptom
- **1**—*Occasionally* have it, effect is *not severe*
- **2**—*Occasionally* have it, effect is *severe*
- **3**—*Frequently* have it, effect is *not severe*
- **4**—*Frequently* have it, effect is *severe*

Category	Score	Symptom
HEAD	________	Headaches
	________	Faintness
	________	Dizziness
	________	Insomnia
	TOTAL ________	
EYES	________	Watery or itchy eyes
	________	Swollen, reddened or sticky eyelids
	________	Bags or dark circles under eyes
	________	Blurred or tunnel vision
	TOTAL ________	
EARS	________	Itchy ears
	________	Earaches, ear infections
	________	Drainage from ear
	________	Ringing in ears, hearing loss
	TOTAL ________	
NOSE	________	Stuffy nose
	________	Sinus problems
	________	Hay fever
	________	Sneezing attacks
	________	Excessive mucus formation
	TOTAL ________	
MOUTH/ THROAT	________	Chronic coughing
	________	Gagging, frequent need to clear throat
	________	Sore throat, hoarseness, loss of voice
	________	Swollen or discolored tongue, gums, lips
	________	Canker sores
	TOTAL ________	
SKIN	________	Acne
	________	Hives, rashes, dry skin
	________	Hair loss
	________	Flushing, hot flashes
	________	Excessive sweating
	TOTAL ________	
HEART	________	Chest pain
	________	Irregular or skipped heartbeat
	________	Rapid or pounding heartbeat
	TOTAL ________	
LUNGS	________	Chest congestion
	________	Asthma, bronchitis
	________	Shortness of breath
	________	Difficulty breathing
	TOTAL ________	
DIGESTIVE TRACT	________	Nausea, vomiting
	________	Diarrhea
	________	Constipation
	________	Bloated feeling
	________	Belching, passing gas
	________	Heartburn
	________	Intestinal/stomach pain
	TOTAL ________	
JOINTS/ MUSCLE	________	Pain or aches in joints
	________	Arthritis
	________	Stiffness or limitation of movement
	________	Feeling of weakness or tiredness
	________	Pain or aches in muscles
	TOTAL ________	
WEIGHT	________	Binge eating/drinking
	________	Craving certain foods
	________	Excessive weight
	________	Water retention
	________	Underweight
	________	Compulsive eating
	TOTAL ________	
ENERGY/ ACTIVITY	________	Fatigue, sluggishness
	________	Apathy, lethargy
	________	Hyperactivity
	________	Restlessness
	TOTAL ________	
MIND	________	Poor memory
	________	Confusion, poor comprehension
	________	Difficulty in making decisions
	________	Stuttering or stammering
	________	Slurred speech
	________	Learning disabilities
	________	Poor concentration
	________	Poor physical coordination
	TOTAL ________	
EMOTIONS	________	Mood swings
	________	Anxiety, fear, nervousness
	________	Anger, irritability, aggressiveness
	________	Depression
	TOTAL ________	
OTHER	________	Frequent illness
	________	Frequent or urgent urination
	________	Genital itch or discharge
	TOTAL ________	
GRAND TOTAL	**TOTAL** ________	

How committed are you to getting better? (Ex. 10% - 100%) ______

Why? ____

Are you willing to do whatever it takes to get better? ______

Are you ready to make any changes necessary to get better? ______

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Consent & **Payment**

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.

Initial__________

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.

Initial __________

I understand that any billing of my insurance company is a courtesy provided by my doctor and that I am ultimately responsible for 100% of my bill. Should I fail to pay in full, I will be responsible for collection costs. Cancellation Made With Less Than 24 hour notice will be charged $25.00 for the first occurrence, and the full cost of the visit for additional occurrences. Our consultation fee is $40 per 20 minutes.

Initial _________

MAJOR MEDICAL INSURANCE

Although we cannot guarantee any reimbursement from your health insurance company, we are glad to answer any questions concerning the billing process. As a courtesy to you, we will bill your insurance company. Please provide a copy of your insurance card whenever your plan renews or changes. If your plan requires precertification it is your responsibility to inform us in writing when It is required. It is not our responsibility for missing insurance company precertification requirements. If your plan changes due to COBRA or other policy changes it is your responsibility to inform us in writing of these changes. Your reimbursement may be affected because of these items ultimately it is your responsibility.

Initial __________

In signing below, I understand all these policies and agree to pay for treatments accordingly, and also 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 AIMC may report me to a credit-reporting agency or take legal action as necessary to be paid for services rendered.

PATIENT SIGNATURE ____ **DATE**____________________