AIMC | ACUPUNCTURE & INTEGRATIVE MEDICAL CENTER

New Patient **Intake Form**

1.Today's Date:

Name:

Date of Birth:

Age:

Gender at birth: Male Female

Height:

Weight:

Address:

Apt./Unit #:

City:

State:

Zip Code:

Home Phone:

Cell Phone:

Email:

Occupation:

Work Phone:

Referred by:

2.Emergency Contact

Emergency Contact Name:

Relationship:

Phone:

3.Do you have health insurance?

Yes

No

4.Insurance Details

Primary Insurance Company

Member ID / Policy #

Group Number

Insurance Customer Service Phone Number

Client Relationship to Insured

Self Spouse Child Other

Guarantor's Full Name

Guarantor's Date of Birth

Guarantor's Phone Number

Guarantor's Full Address

6.Primary Care Physician:

Phone:

972.444.0660 | info@dr.chapa.com | www.aimcdfw.com

7.Other healthcare practitioners treating you:

	Name	Specialty	Phone
1			
2			
3			

Main Complaint:

8.Reason for visit:

9.How is this issue affecting you? How important is this to get better to you and why?

10.List all previous treatments for this condition (including medication):

11.Allergies (medication / food / other)

Medical History:

12.Check all that apply and include medication:

AIDS/HIV	Diabetes Mellitus	
_____	_____	Herpes (oral, genitals)
Tuberculosis	Cancer	_____
_____	_____	Hepatitis (type)
Thyroid disorder (type)	Stroke	_____
_____	_____	Seizure
		_____

13.List any previous surgery/major trauma with date :

14.Current medication/supplements:

Medicine	Dose/Frequency	Reason for Use

Family Medical History:

15.List major medical conditions:

	Medical Condition
Father	
Mother	
Siblings	

Lifestyle:

16.Do/did you smoke?

○ No ○ Yes

17.What type? Explain for how long, and year quit if it applies.

_____

○ Vaping ○ Cigarettes ○ Cigars

18.Do/did you drink alcohol?

○ No ○ Yes

19.What type of alcohol and how much?

_____

○ Liquor ○ Beer ○ Wine ○ Other _____

20.Do/did you use recreational drugs? If yes, what type and how much?

○ No ○ Yes _____

21.Do you regularly consume any of the following, if so explain how many cups?

Energy Drinks	Coffee	Soda / Diet Soda
_____	_____	_____

22.How stressed are you ? No Stress Low Medium High Extreme

Stress Level ○ ○ ○ ○ ○

23. Explain reason why?

_____

24.Do you exercise? If yes, what type and how often?

○ No ○ Yes _____

25.Describe your typical diet: Describe the types of food you eat: Describe what you drink

Breakfast _____

Lunch _____

Dinner _____

26.How much water do you consume in one day? _____

27.Food allergies: _____

28.Food cravings: _____

29.Do you have any difficulty sleeping?

○ No ○ Yes

hours of sleep: Bed Time Awaken:

_____

Women's Wellness & Gynecology:

30.Date of Last Pap Smear: Results

_____

Length of Cycle: Date of Last Menstrual Period: Periods: ○ Regular ○ Irregular

_____

Method of Contraception: Age of Menopause: Do / Did you have clots with menstrual flow?

○ No ○ Yes

_____

# of Pregnancies: # of Live Births: Do / Did you have Ovarian cysts?

○ No ○ Yes

_____

Do / Did you have Endometriosis? ○ No ○ Yes Do / Did you have have hot flashes

○ No ○ Yes

31.Do you get menstrual cramping? ○ No ○ Yes Do / Did you have uterine fibroids?

○ No ○ Yes

If yes, location: _____

32.Do you get PMS Symptoms? ○ Bloating ○ Headache

○ Food cravings ○ Breast tenderness ○ Mood changes ○ Low back pain

33.Date of Last Prostate Exam: Results:

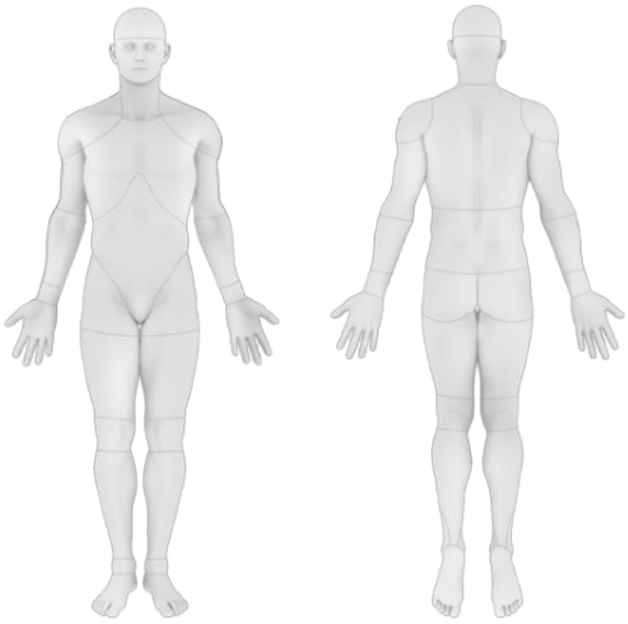
Conditions: ○ Premature ejaculation ○ Impotence ○ ED

General Pain Index Questionnaire:

34.Please choose which best describes how your typical level of pain affects these six categories.

	No Pain	Mild	Moderate	Severe	Extreme
1. Family/At-Home Responsibilities—such as yard work, chores around the house, or driving the kids to school.	○	○	○	○	○
2. Recreation—including hobbies, sports, or other leisure activities.	○	○	○	○	○
3. Social activities—including parties, theater, concerts, dining out, and attending other social functions.	○	○	○	○	○
4. Employment—including volunteer work and homemaking tasks.	○	○	○	○	○
5. Self-Care—such as taking a shower, driving, or getting dressed.	○	○	○	○	○
6. Life-Support Activities—such as eating and sleeping.	○	○	○	○	○

35. Please mark areas that are painful and explain:



Symptoms

Rate each of the following symptoms based on your typical health profile for the past month : 0 - N/A | 1 - Mild | 2 Moderate | 3 Severe

General	0	1	2	3
Poor Appetite	○	○	○	○
Increased Appetite	○	○	○	○
Weight Loss	○	○	○	○
Fever	○	○	○	○
Chills	○	○	○	○
Night Sweat	○	○	○	○
Frequent Illness	○	○	○	○

Eyes				
Watery or itchy eyes	○	○	○	○
Swollen, red, or sticky eyelids	○	○	○	○
Bags or dark circles under eyes	○	○	○	○
Blurred or restricted vision	○	○	○	○
Poor Vision	○	○	○	○
Nearsightedness	○	○	○	○
Floaters	○	○	○	○

Nose				
Stuffy nose	○	○	○	○
Sinus problems	○	○	○	○
Hay fever	○	○	○	○
Sneezing attacks	○	○	○	○
Sinusitis	○	○	○	○
Mucus / Phlegm	○	○	○	○
Allergies	○	○	○	○

Skin				
Acne	○	○	○	○
Hives	○	○	○	○
Flushing	○	○	○	○
Excessive sweating	○	○	○	○
Dry skin	○	○	○	○
Eczema	○	○	○	○
Itching	○	○	○	○
Ulcers	○	○	○	○
Rashes	○	○	○	○

Respiratory				
Chest congestion	○	○	○	○
Asthma, bronchitis	○	○	○	○
Shortness of breath	○	○	○	○
Difficulty breathing	○	○	○	○
Coughing	○	○	○	○
Respiratory Allergies	○	○	○	○
Difficulty Breathing	○	○	○	○
Coughing Blood	○	○	○	○
Pneumonia	○	○	○	○

Urinary				
Frequent / urgent urination	○	○	○	○
Painful to urinate	○	○	○	○
Bloody urination	○	○	○	○
Urinating a lot at night	○	○	○	○
Incontinence	○	○	○	○

Head	0	1	2	3
Headaches	○	○	○	○
Faintness	○	○	○	○
Dizziness	○	○	○	○
Facial Pain	○	○	○	○
Hair loss	○	○	○	○
Dandruff	○	○	○	○

Ears				
Itchy ears	○	○	○	○
Earaches, ear infections	○	○	○	○
Drainage from ear	○	○	○	○
Ringing in ears	○	○	○	○
Hearing loss	○	○	○	○

Mouth / Throat				
Chronic coughing	○	○	○	○
Gagging, frequent need to clear throat	○	○	○	○
Sore throat	○	○	○	○
Swollen or discolored tongue, gums, lips	○	○	○	○
Canker sores	○	○	○	○
Tongue or lip ulcers	○	○	○	○
Hoarseness / loss of voice	○	○	○	○
Feeling something caught in throat	○	○	○	○
Teeth grinding	○	○	○	○
Dental problems	○	○	○	○

Heart				
Chest pain	○	○	○	○
Irregular or skipped heartbeat	○	○	○	○
Rapid or pounding heartbeat	○	○	○	○
High blood pressure	○	○	○	○
Low blood pressure	○	○	○	○
Fainting	○	○	○	○
Swollen hands or feet	○	○	○	○
Blood clots	○	○	○	○
Bruise easily	○	○	○	○
Bleed easily	○	○	○	○

Digestion				
Nausea	○	○	○	○
Diarrhea	○	○	○	○
Constipation	○	○	○	○
Bloated feeling	○	○	○	○
Belching, passing gas	○	○	○	○
Heartburn / Gastritis	○	○	○	○
Intestinal/Stomach pain	○	○	○	○
Vomiting	○	○	○	○
Burping	○	○	○	○
Bad breath	○	○	○	○
Hurts when defecating	○	○	○	○
Bloody defecation	○	○	○	○
Black stools	○	○	○	○
Hemorrhoids	○	○	○	○

Weight	0	1	2	3
Craving certain foods	○	○	○	○
Excessive weight	○	○	○	○
Water retention	○	○	○	○
Underweight	○	○	○	○
Compulsive eating	○	○	○	○

Energy / Activity				
Fatigue	○	○	○	○
Hyperactivity	○	○	○	○
Restlessness	○	○	○	○
Sluggishness	○	○	○	○

Joints / Muscle				
Pain or aches in joints	○	○	○	○
Pain or aches in muscles	○	○	○	○
Stiffness / limitation of movement	○	○	○	○
Feeling of weakness	○	○	○	○
Arthritis	○	○	○	○
Muscle Fatigue	○	○	○	○

TOTAL

Neurological	0	1	2	3
Epileptic Seizures	○	○	○	○
Numbness	○	○	○	○
Tingling	○	○	○	○
Trauma / Head injury Facial	○	○	○	○
Paralysis	○	○	○	○

Mind				
Poor memory	○	○	○	○
Confusion, poor comprehension	○	○	○	○
Difficulty in making decisions	○	○	○	○
Stuttering or stammering	○	○	○	○
Slurred speech	○	○	○	○
Learning disabilities	○	○	○	○
Poor concentration	○	○	○	○
Poor physical coordination	○	○	○	○
Apathy	○	○	○	○

Emotions				
Mood swings				
Anxiety, fear, nervousness	○	○	○	○
Anger, irritability, aggressiveness	○	○	○	○
Depression	○	○	○	○
	○	○	○	○

How committed are you to getting better? Explain why with goals and details

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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 immedi- ately notify a member of clinical staff of any unanticipated or unpleas- ant 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 acu- puncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is anoth- er 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 nutri- tional supplements (which are from plant, animal, and mineral sourc- es) 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 treat- ment 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 pa- tient records and lab reports, but all my records will be kept confiden- tial 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**_____