Traditional Chinese Medicine/ Acupunture New Patient Intake Form Date:_____

Full Name:

_____

First Middle Last

Address:

_____

Cell Phone: _____ Please Circle : **email** or **text** appointment reminders?

Email: _____DOB: _____- _____-_____

YYYY MM DD

Children: Yes_____No_____ Gender and Ages: _____
Occupation: _____ Past Occupations: _____
Emergency Contact (name): _____ Phone: _____
Relationship: _____

How did you hear about our clinic? (check one) Website:_____ Referral: _____ (If so, whom may we thank?) _____ Other: _____

Medical History Current Health Concerns (please list in order of importance and how long it has been an issue)

1)

_____

2)

_____

3)

_____

Please list any: serious injuries, illnesses, hospitalizations, surgeries and conditions along with approximate dates.

_____
_____
_____

_____

Allergies: (Drug, Environmental, Food, Herbs, Vaccines, etc.)

_____
_____
_____

Childhood Illnesses: (Allergies, Asthma, Chicken Pox, Ear Infections, Eczema, Frequent Cold/Flu, Measles, Mumps, Polio, Rubella, Scarlet Fever, Whooping Cough, etc.)

_____
_____
_____
_____

Are you currently taking any supplements? (Herbs, Homeopathics, Minerals, Non-prescription, Over- the-counter, Vitamins, etc.)

_____
_____
_____
_____
_____

Have you used antibiotics? If yes, when and for what was your last dose?

_____
_____

Please list all current prescription medications as well as the dosages:

_____
_____
_____
_____
_____F

Family History: Please check all of the following that apply to you/your family and who:

○ Alcoholism ○ Heart disease ○ Allergies/Hay fever ○ High blood pressure ○ Arthritis ○ High cholesterol
○ Asthma ○ Hypo/Hyper thyroid ○ Auto-immune ○ Irritable Bowel ○ Cancer (type) ○ Kidney disease
○ Depression ○ Liver disease ○ Diabetes ○ Mental Illness ○ Drug abuse ○ Osteoporosis
○ GERD/hiatalhernia ○ Stroke ○ Gout ○ Ulcers ○ Headaches

Do you get regular screening tests by another doctor (Blood tests, physical exams, etc.)? Yes _____ No _____

How many cups per day do you drink of each of the following and do you add sugar/milk: Coffee _____ Black Tea _____ Herbal Tea _____ Do you drink alcohol? _____ If yes, how many drinks per week? _____ Do you smoke? _____ If yes, when did you start and how much? _____ Do you use recreational drugs? _____ If yes, what and how often? _____

Describe a typical day's diet:

Breakfast

_____

Lunch

_____

Dinner

_____

Snacks

_____

Beverages (water/juice/pop)

_____

Do you exercise regularly? _____ If yes, how much and how often? _____

How would you describe the emotional aspect of your home?

_____

_____

How stressful is your work and other aspects of your life? How do you manage stress?

_____

_____

_____

Do you travel? List places and areas visited and any illnesses during the trip?

_____

_____

_____

Do you have any concerns or reservations in pursuing complementary/alternative therapies? If yes, what would those be?

_____

INFORMED CONSENT Please read disclosure fully before your first appointment and before signing consent traditional Chinese medicine is the treatment and prevention of diseases by natural means. TCMDs assess the whole person, taking into account the mental, physical, emotional and spiritual state of that person. Gentle, non-invasive techniques are used to stimulate the body's inherent ability to heal. The TCMD will take a thorough case history and do a physical exam if necessary. Any recent bloodwork or medical tests may be reviewed if provided. It is very important that you inform your TCMD of any condition or disease that you currently have and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or are breastfeeding, please advise your TCMD immediately. There are some slight health risks associated to treatment by traditional Chinese Medicine. These include but are not limited to: aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain, bruising or injury from acupuncture, fainting, or puncturing of an organ with an acupuncture needle. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless expressly directed by myself or law requires it. I understand that I can look at my medical records at any time and that I can request a copy by paying the appropriate fees. I understand that the TCMD does not guarantee results. I do not expect the TCMD to be able to anticipate and explain all the risks and complications. With this knowledge, I voluntarily consent to procedures mentioned above, except for:

_____.

I am free to withdraw my consent and to discontinue treatment at any time. I understand the full meaning of this consent form.

Patient/Guardian Name (Printed) _____

Patient/Guardian Signature _____

Date _____